Report

External Review of Maternity Services
the King Edward VII Memorial Hospital, Falkland Islands

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Glossary of abbreviations

AC	abdominal circumference
AN	antenatal
BF	breast feeding
BP	blood pressure
CMO	chief medical officer
CQC	Care Quality Commission
CTG	cardiotocograph
EFW	estimated fetal weight
EMIS	KEMH electronic patient notes
GBS	group B streptococcus
HC	head circumference
HV	Health Visitor
IV	Intravenous
MDT	multi-disciplinary team
MEOWS	Modified Obstetric Early Warning System
MO	medical officer (doctor)
ODP	operating department practitioner
PET	pre-eclampsia
PN	postnatal
PTSD	Post Traumatic Stress Disorder
SEA	significant event analysis
SFH	symphysiofundal height measurement
SI	serious incident
UA	urine analysis
USS	ultrasound scan
VTE	venous thromboembolism

1. Aim of the review:

- The aim of this external, independent review is to provide The King Edward VII Memorial Hospital (KEMH) management, the family of Baby Aspyn, and the wider community, assurance that the action plan developed following an external review in March 2024 of the events surrounding her birth, has been rigorously implemented, and to provide a more holistic review of maternity services in the Falkland Islands with recommendations for further improvements.
- The review is also intended to provide the opportunity for service user engagement to assist with planning and developing future service provision, as well as identity improvement and development opportunities in addition to those already included in the action plan.

2. Terms of reference (scope) of the external review:

- To review, critique and assess progress against the 42-point action tracker compiled in respect of the previous external and internal reviews, and;
- Where necessary, and where it is assessed that any action with the action tracker has not been completed to clearly indicate to what extent implementation has occurred and indicate what further work is required to complete the action.
- Provide an objective and balanced assessment of the overall current status of the maternity service in the KEMH.
- Consider all lines of enquiry through the lens of five key questions;
    - Is it safe?
    - Is it effective?
    - Is it caring?
    - Is it responsive to people's needs?
    - Is it well-led?
- To specifically critically review;
    1. Existing policies, procedures and guidance in respect of the maternity service.
    2. The current strategy of the KEMH in respect to how maternity services are provided.
    3. The governance structure/ framework for maternity services.
    4. The adequacy of current arrangements in relation to current equipment, resources and service support.

5. The adequacy of current arrangements in relation to staffing and skill mix.
6. The adequacy of current arrangements in relation to record keeping and documentation.
7. The adequacy of current arrangements in respect of training and development.
8. The adequacy of current arrangements in relation to reporting and investigating incidents and significant event analyses.
9. The adequacy of current arrangements in relation overseas obstetric advice, support and referral.

- To review any significant event analyses (SEA) conducted in the last two years and provide an assessment of their quality and findings.
- To provide the opportunity for input from service users to help inform recommendations for future service improvement and development. This to include:
    - The opportunity for service users to provide feedback to inspectors via e-mail in advance of the inspection. The identity of any individuals who share feedback via this route will not be shared with the KEMH unless in circumstances where serious safety or safeguarding concerns are raised which may place a professional or moral obligation on the inspection team to report the issue further where it is assessed that not doing so would place an individual or individuals at serious risk.
    - Arrange meetings with individuals who provide feedback, at the discretion of the inspection team.
- To make recommendations for future improvement and development of maternity services.
- All recommendations must consider the unique environment of the Falkland Islands and be realistic and achievable in a small island setting with clear limitations as to resources.
- Provide senior management and MLAs with an initial overview of the key findings prior to departing the islands.
- Produce a comprehensive report of the review, including findings and recommendations that can be made publicly available.

3. Context

The King Edward VII Memorial Hospital (KEMH) is a GP-led healthcare facility, responsible for the provision of all primary and secondary healthcare in the Falkland Islands.

On-island pregnancies are managed by GPs with additional postgraduate training in obstetrics, certified by a recognised diploma or equivalent qualification. This care is supplemented by visiting obstetricians, as well as support and advice from an overseas consultant obstetrician.

The remote location of the KEMH, and the small population being served, means that although the KEMH is well-equipped for its scale, it does not have the facilities for specialist neonatal care and is not equipped to manage pregnancies assessed as 'high risk'.

Due to the limited resources available in the islands, mothers that are assessed as being at high risk of complications are offered the opportunity to give birth overseas and must travel overseas by no later than 36 weeks. This referral is ordinarily into the NHS system in the UK, but may, depending on the mother's nationality and preferences, be a different country, or in an emergency to South America. Compliance with overseas referrals is generally high, but patients may refuse this option where it has been recommended.

The overall context of maternity services in the Falkland Islands therefore is one in which risk must be carefully and accurately identified, assessed, evaluated and then appropriately responded to, in order to promote the best possible outcomes in a remote healthcare facility with limits to its resources.

4. Information and evidence gathered/processes used:

- Development of an assessment tool specific to the unique environment of the Falkland Islands based on the Care Quality Commission framework 2025[1] (see appendix 2 for methodology and tool)
- Site Inspection with familiarisation of obstetric care facilities and hospital lay-out, attendance at medical morning handovers, discussions with various members of staff not directly connected with maternity (theatre staff – surgeon, anaesthetist, ODPs, nurses) and governance lead, observation of the weekly obstetric MDT meeting, and an anonymous staff survey to address the assessment tool staff questions

- Interviews with clinical staff involved in maternity
- Interview with the obstetric adviser (UK consultant obstetrician and fetal medicine specialist
- Review of 10 sets of recent maternity notes and notes audit of 8 sets (handheld and Emis) - the proforma used assessed aspects documentation against standards drawn from NICE Antenatal Care NG201[2] and Saving Babies Lives care bundle[3.] Additionally, 10 currently pregnant electronic notes were scrutinised for completion and recording of the antenatal booking venous thromboembolism (VTE) score.
- Review of the notes and SEAs/action plans from 2 recent pregnancies with poor outcome and an interview with the couple from one of the cases
- A press statement was released 27/8/2025 to invite those with experience of using maternity services in the Falkland Islands in the past 5 years to engage with the review by direct feedback to the reviewers (appendix 3: press statement)
- A recent users postnatal telephone survey organised by the maternity team: recent users were contacted by a member of staff unconnected to maternity and the following questions were posed:

  Did you feel you… were treated with kindness?/ were treated with respect?/ had privacy & dignity in hospital?/ were listened to & involved in decision making?/ Have cultural/religious needs respected?
- Appointment of a maternity services champion (see appendix 3) – to engage with the review process and to provide future user representation in maternity services

5. <u>A note from the review team:</u>

We would like to thank all those who responded to our invitation to provide feedback for the review. The stories sent to us were deeply personal and many describe difficult and sometimes traumatic experiences before, during and after birth. We are grateful that you shared these with us. Every email response has been included avoiding identifiable details. We would also like to thank all the members of staff who participated in the review.

6. The findings:

6.1 INSPECTION OF THE SERVICE AND FACILITIES - THE ASSESSMENT TOOL:

Please refer to the completed assessment tool in appendix 5 for details of the inspection and findings.

6.2 INTERVIEWS WITH STAFF INVOLVED IN MATERNITY:

Interviews were held with the 3 midwives currently employed in KEMH, the chief medical officer (CMO), 2 medical officers (MO) who provide obstetric care, ultrasonographer, and governance lead.

Each of the midwives and medical officers commented favourably in their interviews on the new format of delivering antenatal care in a combined antenatal clinic and liked the multidisciplinary team meeting that had been introduced weekly to discuss all currently pregnant individuals. All except one of the medical officers who had newly arrived in the Falkland Islands, had returned to the UK for obstetric training courses and work experience in a UK maternity unit within the last year. Likewise, the ultrasonographer providing the majority of the obstetric scans also returned to the UK for training and work experience and is due to be joined imminently by a locum ultrasonographer from the UK with experience in performing obstetric ultrasound scans. The KEMH has recently invested in the Viewpoint ultrasound reporting and image management system™ which allows for reports to be easily shared with UK fetal medicine units for a second opinion. She explained that a new timetable has been introduced in KEMH whereby all obstetric scanning occurs on the same weekday morning each week followed by the combined midwife/ doctor antenatal clinic appointments in the afternoon. This allows for timely review of the ultrasound reports. The CMO explained that a contract has been formally agreed with a Consultant Obstetrician with a special interest in Fetal/Maternal Medicine from the UK for obstetric advice and guidance on a case-by-case basis. Copies of guidelines and obstetric presentation proformas have been adopted from the UK and adapted for KEMH. This remains work in progress.

Ongoing pregnancies and outcomes are now being logged on an Excel spreadsheet and updated weekly at the MDT meeting. Risk factors, including ethnicity and BMI, as well as mode of birth and infant feeding choices are logged therein. Of note was the seemingly low

breastfeeding rates and paucity of information fed back from UK transfers. The team expressed difficulties in obtaining outcomes and discharge summaries from some overseas births.

All maternity staff have access to the 'Y drive', a secure shared drive location, where spreadsheets and MDT meeting notes, unratified guidelines and other confidential maternity documents are kept. The two more junior midwives both commented on the strong support that they received from the senior midwife and from the medical officers. They have also been encouraged to develop initiatives that help improve the smooth running of the service and feel able to contribute their ideas and opinions at the weekly meetings. They designed, introduced and ran the antenatal classes which owing to numbers have not been organised regularly but planned for when a group of pregnant women are at a gestation to attend and 3 classes are then provided in consecutive weeks. They commented also on the favourable length of antenatal appointment time slots which allow for counselling and information sharing. Both felt comfortable to escalate concerns and commented that the senior midwife makes herself available whenever she is needed and often receives text messages adhoc from the antenatal patients. Between all three they ensure that obstetric care staffing cover is available when needed. In essence there are always two midwives available at any one time. There are however times when owing to simultaneous deliveries or prolonged hospital stays that, for successive shifts to be covered, they must be flexible in their work routine. The senior midwife confirmed that any over time could be paid as such or given as time in lieu.

Incidents are discussed at the obstetric MDT meeting (as per the midwife interviews) and the discussion recorded on the excel database. There is not currently a separate maternity trigger list (see appendix 4 for example) guiding staff as to which incidents should initiate an incident report. The Ideagen Q Pulse quality management software reporting system was demonstrated by the governance lead but this is not currently used by clinicians regularly for incident reporting. The CMO explained that all serious incident reports and SEAs were collated by the governance lead and the records kept on Q Pulse system.

Equipment: there was much visible pride in the freshly painted maternity suite and new ensuite shower room. However, one of the midwives commented on the very old delivery bed which operates manually and cannot be lowered sufficiently for a shorter stature pregnant person to easily climb on or off. The bed however functions well and is fit for purpose.

All midwives are dual trained and whilst some midwifery training is mandated by the Nursing Agency, both junior midwives demonstrated that they were motivated to keep updated with other training relevant to their role including Baby Lifeline CTG and neonatal resuscitation courses.

6.3 MATERNITY NOTES AUDIT:

Results:

Table 1 Audit proforma with results shown

Audit Question	Yes?
BP/UA at each antenatal visit?	BP yes but UA missing multiple appointments in 3/8
For new risks, are plans documented	Yes in 6/8
Recording of SFH measurements	Recorded but not plotted
Documentation of labour plan and patient's wishes	Yes in 6/8 (EMIS) but only 1/8 in handheld notes
USS documented - with AC, HC and EFW plus centiles	Yes but not EFW/centiles
Is each entry timed, dated and signed with name & role	Timed, dated, name (EMIS), signed (notes) but not role except use of name and role stamp of one midwife
Are the notes contemporaneous notes?	Yes & good use of partogram
Handover - evidence of structured handover	0/8 SBARS
MEOWS and perinatal institute labour notes used?	MEOWS 4/8; Perinatal labour notes 7/8 – one labour detailed only on EMIS
Perinatal mental health completed on page D?	Yes in 4/8

VTE score assessment completed on EMIS in 9 out of 10 currently pregnant individuals at booking and evidence of low molecular weight heparin commenced in identified high risk individuals.

In summary: There is consistent recording of blood pressure but not urine analysis; new risks are identified and plans documented. There is consistent recording of symphysio fundal height measurements and plotting of ultrasound measurements. Documentation of labour

plan and birth wishes are found in the antenatal entries on EMIS but only in one set of notes was the labour plan page completed in the Perinatal Institute handheld notes. All entries were signed or electronically named on EMIS. However, the designated roles of staff were not recorded on any entries except in the case of one midwife when she used her name and role stamp. Labour notes were contemporaneous and in 7 of 8 cases handwritten in the Perinatal Institute labour booklet with evidence of use and completion of partograms; MEOWS charts were not found in 50% of cases. Only 50% of perinatal mental health section was completed in the handheld notes. SBAR handover was not evident in any notes.

Discussion: Whilst this represents a substantial improvement in documentation, further attention to detail in record keeping is required. If the correct pages and boxes in the Perinatal Institute handheld notes are used, rather than recording entries electronically on EMIS, the documentation will guide and standardise care and record-keeping and both will be more consistent and complete. This includes detailing the birthplan and woman's wishes for labour on the correct page and the mental health assessment section. Not only do the handheld notes act as a professional prompt, but they are also designed to be completed collaboratively with women and families and contain much necessary detail to ensure safe antenatal, intrapartum and postnatal care is delivered. Of particular importance for the FI, this record follows the woman and so where transfer overseas is necessary all the information is captured in one place.

Reviewers note the absence of the baby record. Neonatal care should be documented in the baby's record which is a separate document to the mothers.

Viewpoint reporting has only just been introduced, supersedes and improves on the previous ultrasound documentation seen in this audit with now standardised recording of EFW and centiles. The new schedule of growth scans offered to pregnant persons in the Falkland Island obviates the symphysiofundal height measurement recordings. MEOWS observations for short antenatal admissions have been entered on a plastic wipe board MEOWS chart rather than using the standard paper version and this may explain their absence in 50% of the medical notes.

SBAR handover is not visible in the notes – often this is because the continuity of care is between the same two members of staff with a lengthy overlap of care.

Audit conclusion:

1. Fully complete handheld maternity notes ensuring birth plan is discussed and documented.
2. Involve women and their families in record keeping.
3. Complete individual MEOWS charts for all admissions of pregnant persons.
4. Ensure all entries are signed, timed and dated with name clearly visible and professional role.
5. Handover should be evidenced in the notes, most easily achieved with SBAR stickers.
6. Regular audit of maternity notes.
7. Introduce baby/neonatal perinatal institute record.

6.4 A REVIEW OF SEAs AND IN-PERSON COMMUNICATION OF EXPERIENCES:

Details of the pregnancies and the assessment of the SEAs undertaken on each have been appended in separate documents that should not be made available to the public in order to respect confidentiality. It is only the findings that require further recommendations that are summarised here:

SEA 1:

Additional recommendations

- Fetal monitoring (computerised cardiotocograph) must be instigated at new onset hypertension/PET as per NICE hypertension in pregnancy guideline (NICE: Hypertension in pregnancy: diagnosis and management 2023 https://www.nice.org.uk/guidance/ng133)[7].
- When FGR is suspected an assessment of fetal wellbeing should be made including a discussion regarding fetal movements and if required computerised cardiotocograph (cCTG) (SBLcb v3.2)[3].

SEA 2

Additional recommendations

- Ensure all observations are completed at each contact as per the KEMH Antenatal Guideline
- Ensure passport at booking – and in date

- Improve the support mechanism and information given to a couple being transferred in emergency /medical reasons – develop maternity transfer booklet with relevant information for accessing care
- Debriefs: Avoid use of emotive comments
- Ensure wider transferring-overseas team are sensitive to the high risk nature of the pregnancy and associated stress
- Optimise bereavement care in FI

6.5 SERVICE USER EMAIL FEEDBACK

Feedback was received from 23 users. Common themes were drawn out from each response and highlighted below. The feedback ranges from early 2020, during Covid and beyond. It is encouraging that many of the concerning points raised have already been addressed in the past 18 months.

Summary of patterns/themes that emerged in the feedback:

- What worked well: Continuity with trusted midwives, compassionate individuals, responsive emergency care, health visitor support.
- What required improvement: Lack of antenatal information, patchy postnatal support, concerns about clinical records, poor overseas referral process, weak complaint handling and inconsistent professionalism.

Themes with illustrative quotes (and mentions)

Theme 1: Staff attitudes & professionalism (20/23)

- Strong, repeated praise for specific midwives, including life-saving action *"Could not have felt more supported and respected… acted quickly, forever grateful." and "I couldn't fault the care once I showed early signs of pre-eclampsia."*
- Isolated concerns about reassurance, technique and manner *"Midwife opened door saying 'what are you doing here again?'"*, empathy and respect - some service users felt dismissed, ignored or unwelcome *'I felt ignored, she didn't want to understand what I was saying and I was treated like a stupid person'*

Theme 2: Information & antenatal education (19/23)

- Some shared positive experiences *"I was informed during check-ups about anything necessary and was always spoken through what they were doing and for what reasons…"*
- Others reported minimal proactive information, reliance on self-research, absence of antenatal classes, no standardised information leaflets or booklets *"There were no pre-natal classes… I think would have helped me cope in my labour better."* and *"There were basics that were never mentioned, I never came out feeling like I'd been informed."*

Theme 3: Continuity, access & communication (19/23)

- Good access *"Met me at hospital within hours when I thought I was in early labour."*
- Some service users appreciated easy access to their midwife *"She was available via mobile phone anytime for questions or any issues though which was great."* but others felt uncomfortable that personal mobiles were used as default contact *"Given a personal mobile to text—felt unprofessional, I avoided using it."*
- Missed bookings, unclear escalation routes, poor communication when non-English first language.

Theme 4: Clinical governance & safety (18/23)

- Poor documentation *"No notes were put on my record apart from 'seen patient."*
- Poor consent/briefing for sweeps *"Multiple stretch & sweeps, little info, possibly not in my/my baby's best interests (COVID pressures)."*
- Delays in escalation.

Theme 5: Postnatal support & follow-up (16/23)

- Postnatal support could be supportive *"Visited daily for 10 days—reassuring when baby was jaundiced."* but also described as patchy, inconsistent or absent *"I was exhausted and dazed and no clue about what to expect with the changes to my body"*
- Others said they felt abandoned, with no plan of who to contact if problems arose, *"I was never given a follow up appointment with a midwife to have a check on my health*

post-birth", unclear who to contact for care post birth or communication of when handover to HV/GP happens.

Theme 6: Mental health & Trauma (14/23)

- Lasting impacts (anxiety, flashbacks, PTSD) *"Labour/post-birth still haunts me 5+ years later."*, bereavement, fear affecting future family plans *"Memory of baby born not breathing has lingered, closed the door on more children."*, lack of explanation amplified stress.

Theme 7: Overseas referral pathway (11/23)

- Late consultant review and rationale for transfer not clearly communicated, unclear handover, UK logistics stressful, no support once overseas *"We were abandoned once we left the Islands, the UK hospital didn't even know who I was."*
- Missing records on arrival *"People kept asking for details of my medical records and important things were missing and I was trying to phone and call KEMH but most of the information had not been recorded (most recent blood pressures, diabetes tests).", delayed medivacs"*

Theme 8: Breastfeeding/infant feeding (10/23)

- Early formula recommendation without exploring support *"I did not feel supported in my breastfeeding journey"*
- Lack of support/technique/tools/coaching *"I really wish there had been more information and support for breastfeeding."* poor consistency of advice between practitioners.

Theme 9: Complaints & feedback handling (7/23)

- Investigations acknowledged but some service users were unhappy with poor communication, were unsure of the process to complain, or had fears of reprisals and anonymity *"Didn't submit complaint—felt it would go straight to person complained about."*

Theme 10: Partner involvement (6/23)

- *"Midwife even offered to show my husband the maternity room — small touches like that reassured us."* but some mentioned that partners were under-briefed on what to expect *"Partner never advised how to advocate if things went wrong."*

Conclusion

It was clear from the feedback that many were grateful for the care they have received in KEMH in the past 5 years. The feedback also highlighted where users felt let down or uncomfortable or where they have suffered. The paucity of information sharing, communication, reassurance or debrief were common denominators to many of the stories and are causal in many of the themes.

The reviewers can testify to many positive changes in the maternity service seen during this review which have already improved some of the issues raised above. Those that were not highlighted in the last external review are included this time. Further recommendations are listed in section 10 and aim to ensure a safe and responsive service.

It is acknowledged that whilst we believe it is important that all voices are heard and represented here, we cannot confirm the veracity or the accuracy of the feedback received without betraying confidentiality.

6.6 POSTNATAL SURVEY OF RECENT USERS OF THE SERVICE

Of a cohort of 15 recent users, 9 answered the call and all those reached were happy to provide verbal feedback on their recent experiences. Whilst all were positive in their direct answers to the questions:

Did you feel you…	Cohort 15, tel contact 9
were treated with kindness?	100%
were treated with respect?	100%
had privacy & dignity in hospital?	100%
were listened to & involved in decision making?	100%
Have cultural/religious needs respected?	100%

Table 3 postnatal survey

Each were happy to elaborate on their answers, and these include the following:

-absolutely helpful with how they helped me before, during my labour and after.

-I had an issue with postpartum care…the doctor was condescending… I should just like to highlight how amazing the (named) midwife was, she was phenomenal.

-felt listened to but not involved in decision making – it depended on midwife, was expected to go with the normal, not necessarily what I wanted. Had one antenatal class which left me feeling more confident and it was shame there were no more. Ended up needing a Caesarean and was not given the information I needed and I found that frightening and frustrating. Grateful for the call.

-grateful to be asked to participate. Issue with nurse opening door when pushing offering tea. (reassured that a curtain now provides privacy on inside of door and will prevent a similar future scenario)

-On a weekend called unwell – just a shame not to be told to go down straightaway, had to call 2nd time. Once I got there care excellent

-had to go to theatre for stitching, felt really cared for by all the staff, really supported

-antenatal classes really important, people did not turn up, really annoyed me that people did not turn up

-re respect: first pregnancy lacking, second pregnancy improved

-changed times of scans with extra one at 36 weeks liked that

-small room cramped when family visit or stay

-very much treated with respect. Asked a lot of random silly questions, they were very professional when answering them. Everything went smoothly, I was really happy with it all.

-as a new parent I would have liked more information. I had to ask questions. I wanted to know what to expect during different trimesters, antenatal classes would have been helpful but was n't aware of dates or venue. Midwife… was very informative gave an in-depth answer to my question

-kindness?: before labour yes, in labour so so; midwife did not hear me when I said my baby was coming, midwife did not pay attention and said it's your first baby you will need to wait longer but my baby came. All other nurses and doctors not have a problem with. Very glad to have been asked about my experience

6.6 INTERVIEW WITH MATERNITY SERVICES CHAMPION

Maternity and Neonatal Voices Partnerships (MNVPs or MVPs)

'An MNVP listens to the experiences of women and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care.

MNVPs ensure that service users' voices are at the heart of decision-making in maternity and neonatal services by being embedded within the leadership of provider trusts and feeding into the LMNS (which in turn feeds into ICB decision-making).

This influences improvements in the safety, quality, and experience of maternity and neonatal care.'

National Maternity Voices – Networking Maternity Voices Partnerships in England

We were pleased to receive emails from several persons volunteering for the role of maternity services champion (known as MVP in UK). Following interview, a maternity champion was selected. Ms Samantha Chapman brings an understanding of the need for

the role, personal experience of the service, knowledge of pregnancy and an enthusiasm and real wish to make a difference for current and future users.

7. <u>Critique of progress against the 42-point action tracker:</u>

Please see attached the 42-point action tracker (**Appendix 6**). The rag rating reflects the reviewers' opinion on progress and can be seen as very favourable. The action tracker reflects the positive progress made to improve safety and quality of care in maternity in KEMH. Comments and further additional recommendations to build on some of the points are stated in the last column.

8. An assessment of the overall status of the maternity services in KEMH

The reviewers were pleased overall to find a very different culture and attitude amongst staff towards maternity in KEMH:

All members of the leadership team, maternity team and wider staff were seen to be dedicated to improving the provision of care in maternity at KEMH; all embraced a multidisciplinary team approach to maternity care and simulation training. Additionally communication both to the women and between staff was much improved.

This was evident in all aspects of the obstetric journey with implemented changes to antenatal care, new initiatives, refreshment of facilities, quality improvement activities, team training events with particular emphasis on simulation drills of category 1 emergency Caesarean sections and work experience in UK.

With respect to the following points of care raised in the TOR:

1. *Existing policies, procedures and guidance in respect of the maternity service.*

Guidelines- this is work in progress - those completed are uploaded to Q Pulse system and accessible to all, those in draft are available on the KEMH "y" drive, a secure shared drive location for obstetrics and accessible only by members of the maternity team. The team are in the process of updating all their guidelines to reflect those obtained from Royal Cornwall Hospital, Truro. Completed updated guidelines include induction of labour, antenatal care, fetal growth monitoring, intrapartum care, emergency Caesarean section, Hypertension in pregnancy, antepartum and postpartum haemorrhage. Of the minimum local KEMH modified guidelines recommended in the last external review, some obstetric emergency guidelines are yet to be finalised. Obstetric emergencies have been the subject of recent training. The team aim to have completed guidelines accessible and maintained in date on both Q Pulse system and Y drive.

Standard obstetric proformas (obtained from Royal Cornwall Hospital) for various antenatal presentations have been introduced into clinical practice and represent a useful guide and reminder of aspects on management and subsequent care.

Procedures relating to emergency operative delivery are embedded and regularly rehearsed in unscheduled simulation training involving all staff at KEMH. Classification of Caesarean section with timeframe to delivery have been widely disseminated and evident on posters near maternity and theatres. The WHO

checklist has been modified to include cord blood gas analysis, and a specific guideline has been written for this.

Prior to the appointment of new maternity medical staff, a list of obstetric core competencies is mandated. These are logged with evidence of completion of training at induction or commencement of the role:

- Interpretation of CTGs
- Indications for Caesarean sections
- Ability to perform vaginal examinations and assess Bishop's score and progress of labour
- Recognition and management of pre-eclampsia
- Management and treatment of obstetric haemorrhage
- Ventouse delivery
- Perineal repair
- Management of retained placenta
- Ability to perform ERPC
- Resuscitation of the newborn
- Management of shoulder dystocia
- Management of preterm labour and premature rupture of membranes
- Induction and augmentation of labour
- Assisting at Caesarean section

Dedicare recruitment agency are formally employed to screen and recruit the surgeons to FI. Emergency and elective caesarean sections are listed as essential criteria. The agency employs a UK surgical advisor who advises Dedicare on a surgeon's suitability and who conducts interviews with each of the applicants to determine the extent of their surgical and obstetric operative experiences. KEMH leadership team are currently in discussion with Dedicare to ascertain the depth of the criteria for obstetric operative experience.

2. *The current strategy of the KEMH in respect to how maternity services are provided.*

Antenatal care follows NICE[2] guidance. Handheld antenatal notes are currently in use alongside EMIS (KEMH electronic patient notes) and have an additional front

sheet providing valuable information in terms of emergency contacts, symptoms of concern, links to resources created by the senior midwife.

Women are contacted by the midwife for a booking appointment. Risks are assessed at this appointment with identification of those who require transfer overseas for delivery. VTE risks are identified and the VTE score is recorded on EMIS. Current practice is to record details of clinical encounters electronically, placing a printed report of each encounter in the handheld notes.

Obstetric ultrasound scans currently occur on same weekday (Wednesday morning) with the combined antenatal clinic appointments (midwives and medical officers) reviewing women in the afternoon. The following morning a ring-fenced obstetric multidisciplinary meeting is attended by all members of the maternity teams (ie the two midwives, three medical officers and two ultrasonographers). An Excel live database is maintained of currently pregnant women including those that have been transferred overseas. Each are discussed in turn at the meeting with multidisciplinary contribution to proposed management which is feedback to the pregnant woman for her consideration if this involves a change and documented on EMIS. Those delivered are recorded on a second sheet within the database with pregnancy outcome. The meeting is also a useful opportunity for education and currently the outcome and learning of recent incidents and audit outcomes are shared here also.

Antenatal classes are provided but are grouped variably to allow for a number of women to be able to attend together.

Antenatal admissions are managed with use of obstetric proformas as an aide memoire and CTG monitoring is instigated when indicated. Recently arrived is a Dawes-Redman computerised CTG machine for use in the antenatal setting. Women are reviewed by the midwife and medical officer on call for obstetrics.

The couple meet with the health visitor in the third trimester.

Birth plans are currently discussed at 34-36 weeks' appointments and detailed on EMIS. Analgesia options have been broadened. Epidural anaesthesia has been introduced and at time of review four service users had opted for this form of pain relief with good effect. There is evidence that postnatal contraception is discussed routinely.

Antenatal and/or labour/induction of labour hospital admissions are discussed at the morning team huddle which the senior midwife attends as well as anaesthetist and surgeon. The theatre team are made aware of any persons in labour. The oncall medical officer for obstetrics reviews the patient on admission and regularly during the labour.

During labour, one to one midwifery care is instigated with the presence of a second midwife or MO at delivery. The obstetric oncall medical officer is required to be within 15 minutes of KEMH in case of the need for additional support or medical input.

If a Caesarean section is indicated, these are performed by the resident surgeon who has mandated obstetric surgical experience prior to arriving in the Falkland Islands. Both surgeon, anaesthetist and oncall theatre staff are expected to be available within 15 minutes.

Postnatal care is given by the midwives with handover of care to the health visitor at generally 10 days postpartum. Postnatal contraception is prescribed or administered immediately postpartum. Postnatal debrief appointments are offered by the CMO/ MOs.

Women identified as high risk are currently transferred overseas at any gestation before 36 weeks – the majority by airbridge to the UK in the third trimester. Accommodation and daily subsistence are provided. General travel guide and information is given. There is no specific maternity information provided for the journey or instructions on arrival or navigating the NHS. There is no Falkland Island travel representative to meet them on arrival. Women are given a contact number in London for further support whilst they are in the UK. They are collected by taxi and taken to their accommodation. They attend planned hospital appointments, with the recommendation to register with a GP practice soon after arrival in the UK.

Following delivery, the return journey is arranged, with the support of the London contact, back to the Falkland Islands. Obtaining a summary of the pregnancy and delivery from the maternity units in the UK is challenging and frequently not achieved.

3. The governance structure/ framework for maternity services.

Since March 2024, monthly governance meetings have taken place to review progress with the 42-point action tracker. This meeting is attended by the governance lead as well as the maternity team leads.

A live Excel database records all pregnancies recent past and present, with outcome data completed on a regular basis. For those delivering overseas, the reason, gestation of transfer and destination are recorded but no outcome data.

Incident reviews currently take place at the M&M meeting or the obstetric MDT meeting. Several audits have been undertaken in several areas of maternity by the team including notes, VTE, post CS wound infection.

Maternity guidelines and draft guidelines and obstetric proformas are accessible to all maternity team in a shared folder. Completed guidelines are uploaded to Q pulse also.

Telephone postnatal request for feedback by an independent member of KEMH staff has been recently introduced and serves a dual purpose of gathering feedback and an opportunity to screen for the need for a postnatal birth debrief consultation with one of the MOs.

4. *The adequacy of current arrangements in relation to current equipment, resources and service support.*

KEMH has a single delivery room, recently redecorated with a newly installed ensuite shower room. The room is of adequate size. A curtain has been placed across the entrance to provide privacy. Much of the equipment relating to delivery (cot, weighing scales, CTG machine etc) are kept in the room but removed when the room is in use (until needed). The resuscitaire is checked monthly and before use and is contained within the room. The delivery bed is fully functional, has lithotomy poles and is easy to use. Oxygen is delivered by cylinders contained in the room. There is a birth ball in the room. A second clinical room is available adjacent to the delivery room if the need arises.

Emergency drug boxes specific for postpartum haemorrhage and eclampsia are stored in the cupboard immediately outside the room. The remainder of drugs are stored in a locked cupboard or refrigerator by the nurses' station on the ward.

Dawes-Redman computerised CTG machine was recently introduced for antenatal fetal assessment. Additional obstetric diagnostic tests available include Actim-Prom, PLGF.

In the event of an emergency Caesarean section, the resuscitaire is transferred to the anaesthetic room where piped oxygen is available. A neonatal cot/ incubator is stored close by and checked regularly (with sticker evidence of date of last check).

5. *The adequacy of current arrangements in relation to staffing and skill mix.*

Currently there are three nurse-midwives who cover the service. All contribute to antenatal care and delivery whilst also working shifts as nurses. There is an understanding by each of flexibility in their work pattern to cover the unpredictable timing and nature of obstetric workload. Of the medical officers, three cover antenatal clinics and obstetric on call, having the required training and past obstetric experience including management of labour and instrumental delivery and neonatal resuscitation.

The surgeon undertakes the Caesarean sections with the assistance of a medical officer or surgical care practitioner.

There are two ultrasonographers, one employed on a permanent basis and one locum.

6. *The adequacy of current arrangements in relation to record keeping and documentation.*

Perinatal institute handheld antenatal and labour care notes have been re-introduced in KEMH but are not yet used to their full potential. Much of the documentation of consultations and events still occurs on EMIS with printed copies laced in the handheld notes in place of handwritten completion of the required boxes and pages. Whilst documentation is more detailed than previously, much information is lost in the bundle of printed entries slotted between the pages of the handheld notes.

The handheld notes serve to remind the clinician of the minimal requirements of each consultation (such as BP, urine analysis, new risk assessment, discussion on fetal movements etc). They also contain valuable information for the pregnant person and an opportunity to record her birth preferences and ideas. Stickers for recording of vaginal examination are in use but not universally adopted. CTG review sheets have been adopted from Royal Cornwall Hospitals and are inserted in the labour booklet for each CTG review in labour.

Scan reports are now in line with Saving Babies Lives care bundle[3] recommendations

7. *The adequacy of current arrangements in respect of training and development.*

Following the outcome of the previous external report, all maternity staff are up to date with the recommended additional training which included Baby Lifeline (https://babylifelinetraining.org.uk) and/or K2 perinatal training Programme, PROMPT course and human factor training in addition to the KEMH mandated ALS and NLS courses. All have undertaken work experience in a UK maternity unit during the past year. In-house obstetric training including skills drill and simulation has been introduced on a regular basis. It is anticipated that attendance at these courses and UK work experience continues on an annual basis.

8. *The adequacy of current arrangements in relation to reporting and investigating incidents and significant event analyses.*

KEMH uses Ideagen Q-Pulse, a quality management software system recently rebranded as Ideagen Quality Management. If used to its full potential for quality activities, it can ensure regulatory compliance, including document (guidelines, staff mandatory training records, appraisal) management, auditing, risk management, and corrective actions. The system adequately meets the requirements for reporting and investigation of incidents and SEAs.

Maternity specific trigger list for incident reporting does not exist in KEMH currently.

9. *The adequacy of current arrangements in relation overseas obstetric advice, support and referral.*

The formalisation of an agreement with a current UK consultant obstetrician and fetal medicine specialist who has visited the Falkland Islands to provide adhoc obstetric advice will ensure that sensible and safe advice is given which takes into account the remoteness of FI. This support is invaluable to KEMH maternity team and has already made a difference to the outcome of a number of pregnancies. Referral to the UK now is managed by contact with the planned maternity unit and

a pre-arranged antenatal appointment facilitated either by the obstetric advisor if fetal medicine review is required or by direct contact by the MO. However, it is not always clear to the team who to approach at the planned maternity unit and a focus on tightening this process and improving the information and support to the pregnant woman is indicated. Pursuing a summary of the outcome of the referral and the pregnancy is challenging but important for both future pregnancy planning for the individual and for governance/ audit.

9. <u>Is the service safe? What are the safety risks and what mitigating factors may improve the service considering the unique environment of the Falkland Islands and be realistic and achievable in a small-island setting with clear limitations as to resources.</u>

Review of safety of midwifery care on the Falkland Islands for low risk women

Midwifery care for women living in the Falkland Islands (FI) is delivered by a small team of midwives, one permanent (soon to be two) and one or two temporary contracted agency midwives who provide antenatal, intrapartum and postnatal care. The continuity of care model (CoC) in midwifery practice is a care philosophy and service delivery model that emphasizes ongoing support by a known midwife or small group of midwives throughout pregnancy, birth, and into the postnatal period. It is a gold standard model of care that supports safer births, better maternal experiences, and more efficient healthcare delivery. It aligns with woman-centered care principles, ensuring that pregnancy and childbirth are approached as natural life events rather than medicalized processes. Implementing and expanding this model is increasingly recognized as essential for achieving equitable, effective, and compassionate maternity care for low-risk pregnancies.

How does this model fit in remote areas that are high risk by default of isolated location?

It was advised in our last maternity review that all women, even low risk, should meet with the obstetric GP at least once in pregnancy and in this way the CoC model of care has been adapted to suit the unique environment of the FI and is more multi-disciplinary. It was not the intention to medicalize low risk pregnancies but rather to encourage a whole team, proactive approach to care and thus mitigate risk by

reviewing risk factors together regularly and improve care in a niche and isolated environment.

In addition, care needs to be delivered by a team who train together, keep up to date (which in essence means annual return to UK setting to upskill), participate in incident reporting and governance including audit and quality improvement, have strong visible leadership and mentorship.

Review of safety of obstetric care for high-risk women

Following implementation of recommendations from the recent SEAs involving women identified as high risk at the booking appointment, care is now delivered by regular joint midwife/ medical officer appointments. The number of obstetric growth scans on high-risk women has been increased with the introduction of an additional growth scan at 24 weeks' gestation and continued 4 weekly thereafter. All scan reports are reviewed at an antenatal consultation on the same day that they are performed and reported on the Viewpoint system which allows for better visual interpretation of the report by the clinicians. An opinion on concerning reports may now be sought from a UK Consultant in fetal medicine without delay. Dawes-Redman CTG monitoring has been introduced to assess fetal well-being where needed. Weekly multidisciplinary obstetric team meeting allows for a collective decision on management by a team of midwives, medical officers and ultrasonographer. Outcome data is gathered prospectively, and new initiatives, guidelines and learning from recent incidents are discussed at the meetings. Monthly governance meetings to continue implementation of points from the action tracker has provided a driving force to implement training, learning and improve up to date clinical practice.

However, the questions remain for the high-risk women:

1. whether the current list of risk factors used at booking appropriately identifies all those who should be classed as high risk and whether appropriate management is instigated in all cases,
2. what additional specialist care would they receive in the UK that they are unable to have access to whilst remaining in the Falkland Islands,

3. is the skill mix and knowledge of the maternity staff at KEMH sufficient to detect and manage maternal and fetal complications when they arise,
4. and hence what is the appropriate gestation that high-risk women should be transferred overseas.

Potential risks impacting safety

The following tables exemplify potential risks inherent to maternity in the Falklands and mitigation:

Table 2.1. CLINICAL RISKS

Risk	Description	Example	Mitigation
Delayed diagnosis and treatment	Limited access to diagnostics, imaging, and specialist review leads to misdiagnosis or delayed care.	Fetal Growth Restriction, preterm birth.	Telemedicine links to specialists; clear escalation and evacuation protocols.
Limited emergency response	Lack of immediate obstetric and neonatal specialist support.	Obstetric and neonatal emergencies.	PROMPT/ NLS training, regular skill drills for emergencies, ad hoc obstetric advice from UK
Professional isolation	Single clinicians working without specialist peer support.	Sonography, increased stress from sole clinical burden, risk of clinical error.	MDT meetings, use virtual support from specialists.

Table 2.2. LOGISTICAL AND ENVIRONMENTAL RISKS

Risk	Description	Example	Mitigation
Transport delays	Bad weather or distance prevents timely patient transfer.	Air support grounded due to fog or winds. Immigration/no passport, weight limit for medevac	Ensure valid passport at onset pregnancy, liaison with air support, monitor BMI and weight throughout pregnancy.

Table 2.3. WORKFORCE AND COMPETENCY RISKS

Risk	Description	Example	Mitigation
Understaffing	Limited personnel available during illness or leave. Difficulty to recruit to permanent positions	Inpatient stays/24 hour cover for sustained days difficult with	On-call systems, rest periods, increase staffing template for MWs

		limited trained staff	
Skill mismatch	Generalist staff have to manage specialist issues.	Midwife covering nursing, GP covering obstetrics, general surgeon performing Caesarean sections	Remote mentoring, decision-support tools, upskill to UK annually.

Table 2.4. ETHICAL AND LEGAL RISKS

Risk	Description	Example	Mitigation
Informed consent	Cultural or communication barriers, lack of discussion around risk and transfer overseas.	Lack of information on pregnancy risk in remote FI, limited information in other languages	Translation, clear consent documentation.
Confidentiality	Small communities make privacy hard to protect.	Difficulty obtaining anonymous feedback or making complaint, breach of confidentiality.	Robust data protection, professional training, maternity champion, 3rd party complaints procedure

Table 2.5. PUBLIC HEALTH AND COMMUNITY RISKS

Risk	Description	Example	Mitigation
Health inequity	Inconsistent access compared to urban populations especially to affordable internet provision and information, lack of fresh food stuffs, public health messaging	Restricted access to online resources, high BMI,	Outreach programs, community partnerships.

Table 2.6. GOVERNANCE AND QUALITY RISKS

Risk	Description	Example	Mitigation
Lack of incident reporting and oversight	Fewer formal governance structures.	Clinical incidences not reviewed or learned from.	Risk trigger list, report incidences as cultural norm, regular audits.
Documentation and data loss	Poor use of paper notes, lack of standardised care, incomplete entries in multiple places, lack of discharge summaries	Missing clinical data, missing patient history.	Secure digital health record with offline backup.

Alternative models of care:

1. Transfer all pregnant women overseas for antenatal care and delivery.

Benefit: all pregnant women will have access to UK standard NHS pregnancy care

Risk: Removes birth choices for those who are low risk, de-skills medical staff for pregnant women inadvertently delivering in FI; adversely affects mental health and wider family and socio-economic impacts

2. Employ permanent consultant obstetrician in the Falkland Islands.

Benefit: able to provide general obstetric care, and operative procedures

Risk: single clinician working without peer support, unlikely to be able to provide specialist evidence-based up to date opinion on specific fetal and maternal medicine complications

3. Use of telemedicine/ virtual antenatal clinics with UK obstetricians/ fetal and maternal medicine specialists to guide care in the Falklands.

Benefit: UK obstetric opinion and plan of management guided by up to date nationally driven recommendations and helps support/ educate FI maternity team

Risk: WIFI insufficient to support telemedicine currently, risk of UK obstetrician not taking into account the limitations of care in the FI.

4. Current model of care but with more robust risk assessment and an individualised discussion and decision on timing of overseas transfer, taking into account their medical condition, disease activity/control, multi-morbidity if present, lifestyle risk factors (smoking and BMI), mental health, family and socio-economic circumstances. Introduce uterine artery doppler analysis at the time of anomaly scan to aid risk stratification of those identified as high risk for uteroplacental disease at booking. Transfer overseas those with positive results by 24 weeks' gestation because of the associated significant risk of FGR before 34 weeks' gestation[4].

Benefit: Low-risk women able to remain with their families in FI for pregnancy and childbirth if they wish; High risk women: individualised decision on timing of transfer (recognising 'one size does not fit all'); allows those that are high risk at booking with normal uterine artery dopplers to remain in FIs until a later gestation.

Risks: some pregnant women remaining in FIs will miss benefit of UK specialist obstetric care for fetal or maternal complications which may impact on pregnancy outcome.

5. Current model of care but with more robust risk assessment and advise all identified at booking as high risk to be transferred overseas by 16 weeks' gestation

Benefit: those with medical conditions such as diabetes will benefit from the one stop diabetic pregnancy care and dietetic advice delivered in UK and this will improve their pregnancy outcome. By standardising the requirement for early transfer, a small cohort with considered 'milder' conditions who may not have transferred early in the current model could benefit from the specialist care which may alter outcome. In addition, fetal medicine opinion and preterm birth clinics will help optimise high risk pregnancies from 16 weeks' gestation.

Risk: significant impact on mental health and wellbeing with social isolation in foreign surroundings from early gestation; impact on the wider family and wellbeing of other off-spring who may be unable to travel overseas, significant cost implications to family and FIG, and impact on employment.

Conclusion

Whilst all considered models of maternity care in the Falkland Islands have inherent risks, mitigation is possible by persistent and close attention to maintaining skills and knowledge, use of aide memoires (up to date guidelines, handheld notes and obstetric proformas), appropriate risk assessment, multidisciplinary team decision making, use of fresh eyes approach to any obstetric concerns, seeking specialist obstetric advice, timely transfer of high risk women or those with complications, regular unscheduled simulation scenario drills, audit/governance, user engagement and public health initiatives to optimise pre-pregnancy health.

It is our opinion that maternity services should continue to be provided in the FI. It is also our opinion that option 4 could provide a means of safer robust individualised assessment on decision of timing of transfer.

10. Recommendations for future improvement and development of maternity services

By virtue of the case examined, the foci of the previous external report were the low risk antenatal care pathway, induction of labour, intrapartum care, fetal monitoring and emergency operative delivery. During this review the care of women identified at booking as high risk and the process of referral to UK obstetric unit and overseas transfer was additionally investigated.

The aim of the following recommendations is to build on the implemented changes to the maternity services following the last external review. They are derived from a more holistic review of maternity services at KEMH for future improvement based on our findings described in section 6.

Preparing for pregnancy

- Optimising health pre pregnancy including smoking cessation, weight loss (if raised BMI) and good nutrition and exercise habits will reduce the risk of stillbirth in a subsequent pregnancy and may avoid the need for overseas transfer in pregnancy[3].
- For women with an existing health condition, disease control or remission at conception reduces pregnancy complications. Pre pregnancy counselling should include a discussion on pregnancy management plan. This should include reasons for recommended transfer overseas and timing of this which may be earlier if pregnancy complications develop that require more specialist input to their obstetric care or investigations/ treatments that are not possible in the FI. This will allow the individual to plan for the socioeconomic consequences, impact on the wider family, and ensure passport in date.

Antenatal care

- Review booking list of risk factors which should prompt overseas referral. Consider layered risk from multimorbidity, deprivation and ethnicity with the inclusion of lower parameters for e.g. BMI (35-40) if additional risk factors or medical conditions present.
- Discuss and agree the list of risk factors with the obstetric advisor as well as agree a strategy for timing of overseas transfer which may include the use of uterine artery Dopplers to aid decision of early transfer.

- Advise all women with type 1 diabetes mellitus regardless of HbA1C level and those women with type 2 diabetes mellitus who at booking have an HbA1c level above 48 mmol/mol (6.5%) to transfer overseas as soon as possible in the pregnancy. This is in order to benefit from multidisciplinary diabetic antenatal care[3] to reduce the significant risk of still birth.
- Ensure that all women with type 2 diabetes and those with gestational diabetes who remain in the FI for a more prolonged antenatal period are managed in accordance with NICE (NG3)[5] including target glycaemic range and with diabetic specialist nurse and maternity team contact every 1 to 2 weeks throughout pregnancy, seeking advice from UK obstetric antenatal clinic team where glycaemic control is a challenge. Those with persistent HBA1C level above 48 mmol/mol (6.5%) at 28 weeks' gestation should be advised of the associated increased risk of stillbirth and neonatal death which has been shown to be 3x higher (OR3)[6] and overseas transfer planned as soon after as possible.
- Fetal monitoring (computerised cardiotocograph) must be instigated at new onset hypertension/PET as per NICE hypertension in pregnancy guideline (NICE: Hypertension in pregnancy: diagnosis and management 2023 https://www.nice.org.uk/guidance/ng133)[7].
- Continue to provide regular antenatal classes accepting that on occasions there may be only one or two persons attending. Introduce breastfeeding information and literature early in pregnancy and revisit regularly as per UNICEF[9]. Continue to develop initiatives that provide information and communication for all pregnant women. This includes multi-lingual options.
- Ensure full completion of the handheld notes and completion of Birth plan
- Ensure all observations are completed at each contact as per the KEMH Antenatal Guideline
- Ensure all medical records are signed with name and legible designation/role clearly printed.
- Consider a single professional contact channel (duty phone + shared inbox) instead of personal mobiles, publish response times, out-of-hours escalation tree.
- Ensure passport in date at booking appointment for all pregnant women

Transferring overseas:

- Early conversation preferably before pregnancy.
- Maternity team to contact the destination maternity unit ahead of departure from FI and ensure a consultant antenatal clinic (or fetal medicine if indicated) appointment is in place for as soon after arrival in the UK as possible as well as a midwife booking appointment.
- Provide the pregnant woman with details of the destination hospital triage contact number for 24/7 emergency advice in UK.
- For those women travelling after 24 weeks of pregnancy with a known fetal or maternal complication, advise her to contact the triage number on arrival in UK to arrange a review +/- CTG in the obstetric MAU of the destination maternity unit.
- Ensure the woman has her handheld notes with her and a doctor referral letter detailing pregnancy events to date.
- Improve the support mechanism and information given to a couple being transferred in emergency /medical reasons – develop maternity transfer booklet with relevant information for accessing care
- Ensure wider transferring-overseas team are sensitive to the high-risk nature of the pregnancy and associated stress
- Explore possibilities of additional support in UK.
- Seek details of events/delivery postnatal.
- Audit high risk transfers and pregnancy outcome.

Scanning

- All members of the maternity team to familiarise themselves with SBLCB v3.2 element 2 – fetal growth: risk assessment, surveillance and management (https://www.england.nhs.uk/long-read/saving-babies-lives-version-3-2/#element-2-fetal-growth-risk-assessment-surveillance-and-management). This will aid ultrasound scan report interpretation and appropriate management. Consider regular education update to maintain knowledge.
- AC and/or EFW <10 centile at the anomaly scan is a high-risk factor and the case should be discussed with the obstetric advisor.
- Consider early recourse to transfer overseas once FGR is diagnosed

- When FGR is suspected an assessment of fetal wellbeing should be made including a discussion regarding fetal movements and if required computerised cardiotocograph (cCTG) (SBLcb v3.2)[3].

Delivery and postnatal period

- Continue regular simulation and PROMPT training and record dates and attendees.
- Consider use of SBARS stickers for clear documentation.
- Consistent use VE stickers.
- Ensure birthing room is free of unnecessary equipment to give more space
- Immediate de-brief with ongoing follow up for staff involved in distressing situations
- Postnatal debrief appointments for any persons seeking clarification on events in their pregnancy and delivery

Bereavement care following miscarriage, stillbirth or neonatal death

- Optimise bereavement care in FI - recommend use SANDS advice and information for postnatal bereavement care – consider Wellbeing service undergo SANDS training[8]

Governance

- Recognise governance as a tool not a chore: it can help facilitate change and support learning from incidents but only if these are routinely logged and actioned.
- Maternity Champion to be involved at all levels – formalise TORs of the role and the expectation.
- Develop a KEMH specific maternity trigger list for an incident report (example given in appendix 4). Any deviation from standard care or any unexpected adverse outcome should be logged using an incident reporting system - not just the serious incidents.
- Share learning from incidents with all stakeholders and staff.
- Recognise that local guidelines set the standards of care and incident reporting monitors those standards, especially in an environment where clinicians vary or are temporary/new.

- Continue to work on completion of additional KEMH adapted obstetric guidelines and ensure they are stored where easily accessible.
- Consider a guideline of the week approach to learning at MDT.
- Use the Perinatal Institute notes as a tool to engage with service users, draw attention to pages they can read and fill in. Make them a collaborative document.
- Continue regular audit of maternity notes.
- Ensure any discussion with external obstetric advisors and management recommendations are clearly documented in handheld notes.
- Management plans from discussion of the patient at the weekly MDT should be recorded in their handheld notes and patient be made aware of the plan.
- Maintain a live database of pregnancies and their outcome including those transferred, reason and gestation and report the data quarterly. This will help inform stakeholders/ users when planning pregnancy and place of birth.
- Develop a maternity specific induction package of information for all new maternity staff.
- Ensure new maternity staff are orientated to the maternity service pathway and folders/ Q pulse. They should have the opportunity to read all KEMH maternity guidelines as part of the induction process and a signed affirmation of familiarity with the guidelines should be recorded alongside all mandatory training courses.
- Ensure that the surgeon either on arrival or before, has documented evidence of training on management of complex operative scenarios including the delivery of the deeply impacted fetal head (manoeuvres/ strategies employed), the application of forceps for the delivery of the free floating head and the technique for the delivery of a baby with breech presentation at Caesarean section.
- Implement complaints tracker with promised response time & outcome letters, share learning in quarterly safety bulletin and via MVP. Ensure timely complaint resolution in full, duty-of-candour + closure letters.
- Continue to provide a regular report of the maternity service to the Health and Medical Services Committee of the Falkland Islands.
- Consider another external review in 3 years to ensure implementation and maintenance of standards.

10. <u>Accountability, monitoring and sharing of learning</u>

Presentation of initial overview of key findings to senior management and MLAs

On Monday 13th October, an initial overview of key findings was presented to the members of the Legislative Assembly of the Falkland Islands Government. These findings were also discussed with the senior management of KEMH (Director of Health and Social Services and the Chief Medical Officer, KEMH in a separate meeting on the same day.

Furthermore, a feedback group discussion was held with all staff at KEMH who are directly or indirectly involved with maternity services. Positive and negative findings were shared. A reminder of the themes previously discussed in March 2024 that remain vital to the continued provision of safe and good quality care was revisited:

- The importance of transparency
- Communication
- Enabling professional challenge in the workplace (all members of the team)
- Recognition of human factors impacting on care
- Documentation and guideline compliance
- Accountability and importance of regular review of pregnancy outcomes for learning
- Fostering good teamwork – with regular wider team training activities including
- Unscheduled simulation scenarios

Interviews were conducted to inform the public on initial findings with Penguin news, FI radio and television.

References

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7. NICE: Hypertension in pregnancy: diagnosis and management 2023 https://www.nice.org.uk/guidance/ng133
8. SANDS training (https://training.sands.org.uk/bereavement-care/)
9. UNICEF (2025) Having-meaningful-conversations-with-mothers.pdf

Appendices

1. **Short curriculum vitae Sophia Stone and Heather Woods**
2. **CQC assessment audit statements and tool**
3. **Press statement – for service user feedback**
4. **Example of serious incident maternity trigger list**
5. **Completed Assessment Tool**
6. **Action tracker**

1. Appendix 1: Short curriculum vitae Sophia Stone and Heather Woods

Dr Sophia Stone MBBS MD FRCOG MAcadMEd DHMSA

Date of Birth : 18.02.70
GMC : 4199975

QUALIFICATIONS

1995 : **MBBS University of London** United Medical & Dental Schools of Guy's & St Thomas' Hospitals (UMDS), London
1999 : **DFFP** Diplomate of the Faculty of Family Planning & Reproductive Health Care
1999 : **DHMSA,** Diploma in History of Medicine of the Society of Apothecaries, London
2004 : **MD University of London** King's College, London
2005 : **MRCOG,** Royal College of Obstetricians and Gynaecologists, London
FRCOG - Admitted as Fellow in 2018
2008 : **SSM Maternal medicine, RCOG**
2010 : **CCT Certificate of completion of training in Obstetrics & Gynaecology, RCOG**
2010 : **QESP (Qualified Educational Supervisors Programme) certificate**
2018 : **Member of Academy of Medical Educators**

CURRENT APPOINTMENTS AND ADDITIONAL ROLES

2009-present : **Consultant Obstetrician & Maternal Medicine,** University Hospitals Sussex NHS Foundation Trust, St Richard's Hospital, Chichester, West Sussex PO19 6SE
2021-present : **Lead for Sussex Maternal Medicine Network, NHS Sussex ICB**
2023-present : **Honorary Associate Professor & Lead for O&G,** Brighton & Sussex Medical School
2024-present : **External examiner for Bristol University Medical School**
2025-present : **RCOG examiner and recently appointed MBRRACE-UK assessor**

I have an interest in maternal medicine and the care of women with multi-morbidity/complexity. In my practice I have two maternal medicine clinics per week and, monthly joint obstetric haematology clinic and monthly attendance at the Maternal Medicine Centre to contribute to our tertiary Sussex maternal medicine service. I maintain an interest in acute obstetrics with an alternate week labour ward session. Until 2021 I also led on diabetes in pregnancy for the Trust. From appointment in 2009 until 2015 I additionally worked as a general Consultant Obstetrician and Gynaecologist, in a 1 in 7 oncall rota with elective gynaecology surgical lists.

From Aug 2021, I worked with Southeast NHSE&I and Sussex commissioners to develop maternal medicine services within Sussex, following a nationally driven directive and continue to work closely with the ICB to improve uptake of our service from pre-/early pregnancy

I have an interest in medical education and oversee the undergraduate O&G curriculum and assessment for Brighton & Sussex Medical School.

RECENT OTHER APPOINTMENTS:

2019-Oct 2024 : **Regional Specialty Research Lead for Reproductive Health & Childbirth**| CRN Kent, Surrey & Sussex | NIHR Clinical Research Network (CRN)
2020-Aug 2024 : **Year 5 regional Sub-Dean** for Chichester, Brighton & Sussex Medical School
2017- 2023 : **Clinical Chair for Obstetrics and Gynecology & Honorary Clinical Professor**, American University of the Caribbean School of Medicine
2018-2021 : **Western Sussex Hospitals NHS FT Less-than-fulltime-training Champion**

OTHER MEDICAL ACTIVITIES

2016- present : Expert advisor for CEGA Group – Air ambulance repatriation service
March 2024 : External obstetric review - the Falkland Islands

HEATHER WOODS

Advanced Midwifery Practitioner

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PROFESSIONAL

NMC registered: 1010602E

EDUCATION

Midwifery BSc(Hons)
University of Northampton
2010

MSc Advanced Practice
University of Brighton
2023

SKILLS

Expert Midwifery Reviewer.

Specialist Midwife Maternal Medicine.

Experience of Midwifery Management and Leadership.

Experience in Quality Improvement initiatives.

Independent prescriber.

About Me

Experienced Senior Midwife with over 15 years in NHS maternity services, I specialise in the care of women with complex medical conditions in pregnancy. Passionate about reducing maternal morbidity and improving health equity, I work across multidisciplinary teams to deliver safe, evidence-based and personalised care. I am actively involved in guideline development, quality improvement, risk assessment, and education.
Skilled in producing expert reviews and reports to support clinical governance, service evaluation, safety via learning through incidents and complaints resolution.

WORK EXPERIENCE

Nov 2022 - present
UHSussex NHS Foundation Trust
Specialist Lead Midwife (Band 8a), Sussex Maternal Medicine Network

- All duties of a registered clinical midwife proficient in hospital based midwifery care at an advanced level.
- Specialist Midwife Maternal Medicine
- Independent Prescriber
- Experience in midwifery leadership and management including initiation and development of the Sussex Maternal Medicine Network and Sub Hub as per national specifications
- Responsibility for regional data collections and reporting of key performance indicators to national team
- Participation in Healthcare Reseach
- Line manager of small team band 7 Maternal Medicine Midwives

March 2024- present
Falklands Islands Government
Expert External Reviewer

- Independently reviewed, critiqued and recommend edits to an already conducted internal review and provided a comprehensive report which was used to inform coroners findings
- Provided advice on a strategy for obstetric care in the Falkland Islands into the future
- Attended coroners court as an expert witness
- Further review of overall safety of maternity care in the Falklands planned Oct 2025

HEATHER WOODS

Advanced Midwifery Practitioner

INTERESTS

Hiking
Fitness
Drawing
Travel

REFERENCES

Frances Barnes
Head of Midwifery
Email: frances.barnes@nhs.net

WORK EXPERIENCE CONTINUED

Jan 2016 - April 2022
UHSussex NHS Foundation Trust
Lead Midwife (Band 7) Antenatal Clinic and Maternity Assessment Unit

- Lead midwife and line manager for two busy maternity wards at two hospital sites within Trust
- Implementation of several QI projects including introduction of BSOTS
- Proven leadership through challenging times: Covid pandemic, special measures, CQC inspections
- Experience in midwifery leadership and management including both local and external investigations into adverse events, appraisals, sickness absence

Nov 2012 - Jan 2016
UHSussex NHS Foundation Trust
Band 6 rotational Midwife

- All duties and responsibilities of a band 6 midwifery as per the NMC code
- Experience of hospital based midwifery and homebirths

Nov 2010 - Aug 2012
Kettering NHS Foundation Trust
Band 5 and 6 rotational Midwife

- All duties and responsibilities of a band 6 midwifery as per the NMC code
- Experience of both hospital and community midwifery

Appendix 2: Assessment tool quality statements and blank version of assessment tool[1]

Assessment Tool: Derived from CQC SAF / Quality Statements Audit

Overview

- This tool is structured to reflect the 5 **Key Questions** the TOR and CQC ask: Is care Safe, Effective, Caring, Responsive, Well-led. Care Quality Commission+2Person Centred Software+2
- Under each key question, there are several **Quality Statements** ("We statements") that your services should meet.
- For each statement, we assess via **evidence categories** (e.g. People's experience, Staff / Leadership feedback, Observation, Patient feedback, Processes, Outcomes).
- We will consider the unique situation of the Falkland Islands and adapt statements and evidence categories accordingly.
- Scale for grading: e.g. *Outstanding / Good / Requires Improvement / Inadequate* (same as CQC)

Template

For each Quality Statement, an overall rating of 1-4 is determined based on further Key Questions broken down into example evidence questions. These were then be drafted into an excel spreadsheet and scored. Recommendations will be suggested based on those findings.

Domain	Quality Statement	Audit Questions	Evidence Categories to consider	Rating	Areas for Improvement / Actions	Timescale

Below are example statements under each Key Question, with sample evidence prompts.

Key Question: Safe

Statement	Example Evidence Categories & Prompts
We safeguard people from abuse and avoidable harm.	Have policies for safeguarding been updated and communicated? Are staff trained? Do people say they feel safe? Are incidents reported / investigated? Are outcomes improved?
We manage risk in a balanced way, supporting people's freedom and protecting from harm.	Risk assessments in care plans? How are changes in risk handled? Interviews with staff and people using service about risk and involvement? Observation of practice when risk arises.
We have enough suitably qualified, competent and supported staff.	Staff rosters; recruitment checks; training records; feedback from staff & people; staff turnover; supervision records.

We manage medicines safely and effectively.	Audits of medicine storage, administration, prescribing; incidents involving medicines; people's experience.
We prevent, control and respond to infection risks.	Cleanliness audits; infection rates data; observation; policies & staff training.
We learn when things go wrong and make improvements.	Incident reports; near-miss logs; root cause analyses; changes made; monitoring of changes.

Key Question: Effective

Statement	Example Evidence Categories & Prompts
We assess people's needs, choices, rights and maintain health and wellbeing.	Care plans; initial & ongoing assessments; feedback from people; outcome measures; staff competence.
We support people to have sufficient nutrition and hydration.	Menus; records of meals; people's feedback; staff training; incidents of dehydration/malnutrition.
We ensure staff are competent, supported, and able to meet people's needs.	Training, supervision, appraisal, specialisms; feedback from staff; observation of practice.
We ensure communication and involvement are effective for all people using the service.	Access to interpreters; aids for communication; how info is presented; people's feedback; observation in interactions.
We promote wellbeing, including mental health, independence and choice.	Activities; involvement; outcomes; support for emotional wellbeing; referral pathways.

Key Question: Caring

Statement	Example Evidence Categories & Prompts
We treat people with kindness, dignity, compassion and respect.	Observation; feedback from people and families; staff training; policies; complaints/compliments.
We involve people in decisions about their care, listening to them and respecting their views.	Care planning evidence; consent processes; feedback; I statements (people say they are involved).
We ensure privacy and dignity.	Layout of premises; staff behaviour; confidentiality; people's stories; observation.

Key Question: Responsive

Statement	Example Evidence Categories & Prompts
We plan services around people's needs, preferences and diversity.	How services are personalised; adjustments for disability; culture / religion; feedback; partner feedback.
We ensure people can access services when they need to.	Waiting times; appointment systems; late cancellations; people's feedback.

We manage transitions, referrals, transfers or discharge well.	Coordination between services; documentation; feedback from people; partners.
We listen to feedback, complaints and act on it.	Complaints policy; logs; outcomes; changes made; people's satisfaction with response.

Key Question: Well-led

Statement	Example Evidence Categories & Prompts
We have leadership and culture that promotes high quality, sustainable care.	Leadership stability; staff morale; values; culture surveys; examples of innovation; how leaders listen & respond.
We have a clear vision, strategy & values, developed with people using services / staff / partners.	Strategic plan; involvement of stakeholders; communication of vision; alignment between values and practice.
We have governance, performance management, audit and quality improvement.	Audit programmes; incident analysis; performance metrics; improvement action plans; follow up.
We engage with staff, promote diversity, support wellbeing.	Staff feedback; equalities monitoring; staff support programmes; absence / turnover data.
We ensure data, information security, record management and transparency.	Data protection policies; record audits; incident reports; how information is used.

Example Rating Scales & Decision Guidelines

- **Outstanding**: Exemplary practice; embedded; consistently exceeds requirements; people's feedback overwhelmingly positive; evidence of innovation.
- **Good**: Meets requirements; some areas of best practice; most feedback positive; outcomes as expected.
- **Requires Improvement**: Some shortfalls in meeting statements; inconsistent practice; feedback mixed; improvements needed.
- **Inadequate**: Significant or systemic failure; people at risk; very poor feedback; urgent action required.

How we used this to assess maternity care in the Falkland Islands

1. **Gathered evidence** in all evidence-categories for each statement.
2. **Self-rated** each statement using the scale.
3. **Documented strengths and areas for improvement**.
4. **Created an action plan**: i.e. who leads, by when, suggest how improvement could be measured.
5. **Suggest this is reviewed regularly** (e.g. quarterly) to track progress, adjust as needed.

Domains: Safe, Effective, Caring, Responsive, Well-Led.

Evidence Sources: Guidelines, audit data, staff interviews, patient feedback, peer review, observations, incident logs.

Action Plan: Record gaps, assign responsible person, set timescales.

Comparison of maternity and non-maternity Key Questions (for reference only):

MATERNITY 1. SAFE	NON-MATERNITY 1. SAFE
Quality Statement 1: Safeguarding (Women, Babies & Families) • Are safeguarding policies (adult & child) up to date and embedded? • Are midwives and staff trained in domestic abuse, FGM, modern slavery, child protection? • Are women confident they feel safe and listened to when raising concerns?	**Quality Statement 1: Safeguarding** • Do people say they feel safe here? • Are safeguarding policies clear, up to date, and followed? • Are staff trained and confident in recognising/reporting abuse?
Quality Statement 2: Risk Management in Maternity Care • Are risk assessments completed at booking, during antenatal care, intrapartum, and postnatally? • Are women actively involved in decisions about risk (e.g. place of birth, VBAC, induction)? • Are high-risk pregnancies identified and escalated appropriately?	**Quality Statement 2: Risk Management** • Are risks assessed and reviewed regularly? • Are people involved in risk decisions? • Is there evidence of balancing safety with freedom/choice?
Quality Statement 3: Staffing & Skill Mix • Do staffing levels meet Birthrate+ / RCM standards? • Are escalation policies in place when staffing is unsafe? • Are neonatal and obstetric staff available when required?	**Quality Statement 3: Staffing** • Are staffing levels safe at all times? • Are staff trained, competent, and supported? • Is there evidence of effective recruitment checks?
Quality Statement 4: Medicines Management • Are controlled drugs stored, prescribed, and administered safely? • Is oxytocin, magnesium sulphate, and emergency medication monitored and audited? • Are errors/near misses in prescribing or administration reported and acted on?	**Quality Statement 4: Medicines** • Are medicines stored and administered safely? • Are errors/near misses recorded and acted on? • Do people understand and consent to medicines they receive?
Quality Statements 5: Infection Prevention & Control • Are theatres, delivery suites, and postnatal wards clean and compliant with IPC audits?	**Quality Statement 5: Infection Prevention & Control** • Are infection prevention policies in place and audited? • Are staff trained and observed following procedures?

- Are women screened and managed for sepsis, GBS, COVID-19 etc. according to policy?
- Are staff observed following hand hygiene and PPE procedures?

Quality Statement 6: Learning from Incidents

- Are serious incidents (HSIB referrals, stillbirths, maternal/neonatal deaths) investigated and shared openly?
- Is there evidence of learning from safety huddles and MBRRACE/Each Baby Counts reports?
- Can staff and families describe changes made after incidents?

2. EFFECTIVE

Quality Statement 1: Assessment & Care Planning

- Are booking assessments comprehensive (medical, obstetric, social, mental health)?
- Are personalised care plans documented and updated?
- Is continuity of carer delivered where possible?

Quality Statement 2: Nutrition & Feeding

- Are women supported in infant feeding (breastfeeding, formula, expressing)?
- Is Baby Friendly Initiative accreditation achieved/maintained?
- Are hydration/nutrition needs of mothers (antenatal & postnatal) assessed and supported?

Quality Statement 3: Staff Competence & Training

- Are all staff trained in CTG interpretation, PROMPT, NLS, maternal resuscitation?
- Is annual skills/drills training carried out (e.g. shoulder dystocia, PPH)?
- Are competencies signed off and monitored?

Quality Statement 4: Communication

- Do women receive information in an understandable format (multiple languages, easy-read, interpreters)?
- Are handovers (SBAR, board rounds, ward rounds) effective and safe?
- Are women and partners kept informed during emergencies?
- Are infection rates monitored and responded to?

Quality Statement 6: Learning from Incidents

- Are incidents recorded, investigated, and lessons shared?
- Have improvements been made following incidents?
- Can staff give examples of changes after things went wrong?

2. EFFECTIVE

Quality Statement 1: Assessment & Planning

- Are needs and choices assessed and regularly reviewed?
- Do assessments cover physical, emotional, and social needs?
- Do people feel their care reflects their goals?

Quality Statement 2: Nutrition & Hydration

- Are meals/nutrition adapted to individual needs?
- Do people say they enjoy and have enough to eat and drink?
- Are hydration checks/audits done?

Quality Statement 3: Staff Competence

- Do staff receive induction, training, and supervision?
- Do staff feel confident to meet needs?
- Is there evidence of competence checks?

Quality Statement 4: Communication

- Do people have support to communicate (interpreters, aids)?
- Do staff adapt communication to people's needs?
- Are records written in accessible ways?

Quality Statement 5: Promoting Wellbeing & Choice

- Are people supported with independence and wellbeing?
- Are mental health and emotional needs considered?

Quality Statement 5: Promoting Wellbeing & Choice

- Do women feel supported to make informed choices about birth and care?
- Is perinatal mental health screening and referral available?
- Are women encouraged to remain mobile, use water, or pain relief options as they choose?

3. CARING

Quality Statement 1: Kindness, Dignity & Compassion

- Do women describe being treated with dignity, kindness, and respect?
- Are birth partners included and supported throughout?
- Are privacy and dignity upheld in wards, clinics, and theatres?

Quality Statement 2: Involving Women & Families in Decisions

- Do women feel listened to during antenatal, intrapartum, and postnatal care?
- Are informed choices respected, even when risk factors are present?
- Are families involved in neonatal decision-making and discharge planning?

Quality Statement 3: Respect for Cultural & Personal Needs

- Are cultural, religious, and language needs understood and respected (e.g. modesty, diet, rituals)?
- Are women's birth preferences (birth plans, pain relief, delayed cord clamping) considered and documented?
- Do staff challenge discriminatory attitudes or behaviours?

4. RESPONSIVE

Quality Statement 1: Personalisation & Diversity

- Are maternity services tailored for diverse groups (teenage mothers, ethnic minority groups, disabled women, LGBTQ+ families)?
- Are outcomes by ethnicity, deprivation, or age monitored and acted upon?
- Are reasonable adjustments in place for disability/communication?
- Are there activities and opportunities for meaningful choice?

3. CARING

Quality Statement 1: Kindness, Dignity & Compassion

- Do people feel staff are kind, respectful, and compassionate?
- Are privacy and dignity respected in practice?
- Do staff go "above and beyond" in their care?

Quality Statement 2: Involving People in Decisions

- Do people say they are listened to?
- Are decisions made with informed consent?
- Do staff explain choices clearly and involve families if appropriate?

Quality Statement 3: Privacy & Respect

- Is confidentiality upheld?
- Do facilities protect privacy (rooms, spaces)?
- Do staff respect cultural and personal values?

4. RESPONSIVE

Quality Statement 1: Personalisation & Diversity

- Are services tailored to individual needs and backgrounds?
- Do people feel their cultural/religious needs are respected?
- Are reasonable adjustments made for disability/communication?

Quality Statement 2: Access to Services

- Do people get timely access to care/support?
- Are waiting times monitored and acted on?
- Are referrals handled efficiently?

Quality Statement 2: Access to Care

- Do women access care early in pregnancy (booking by 10 weeks)?
- Are waiting times for scans, antenatal clinics, induction, and theatre monitored and acted on?
- Do women report delays in receiving care, especially in emergencies?

Quality Statement 3: Continuity & Transitions

- Are women supported through antenatal to intrapartum to postnatal care?
- Is neonatal transfer/discharge safe, coordinated, and well-communicated?
- Are handovers between community and hospital seamless?

Quality Statement 4: Feedback & Complaints

- Are feedback mechanisms (FFT, surveys, listening events, Maternity Voices Partnerships) active and used to improve services?
- Are complaints investigated, with learning shared with staff and women?
- Do women feel confident complaints will lead to change?

5. WELL-LED

Quality Statement 1: Leadership & Culture

- Do maternity staff describe leadership as visible, approachable, and supportive?
- Are safety huddles, walk-arounds, and Schwartz rounds embedded?
- Is there a culture of openness and learning, not blame?

Quality Statement 2: Vision, Strategy & Values

- Is there a clear maternity improvement plan (aligned with Ockenden, Kirkup, MBRRACE)?
- Are families, MVPs, and staff involved in shaping priorities?
- Do staff understand and live the vision/values?

Governance & Improvement

- Is there strong governance for maternity safety (MSDS data, dashboards, CNST standards)?
- Are risks escalated to Board level and reviewed regularly?

Quality Statement 3: Transitions & Continuity

- Are transfers/discharges planned well?
- Do people feel supported at transition points?
- Is information shared appropriately between services?

Quality Statement 4: Feedback & Complaints

- Is there an accessible complaints process?
- Are complaints responded to promptly and fairly?
- Can people describe improvements made after complaints?

5. WELL-LED

Quality Statement 1: Leadership & Culture

- Do staff describe leadership as supportive and open?
- Are values and vision visible in practice?
- Is there evidence of innovation and improvement culture?

Quality Statement 2: Vision, Strategy & Values

- Are values developed with staff/people using services?
- Are they communicated effectively?
- Are they reflected in everyday decisions?

Quality Statement 3: Governance & Improvement

- Are there effective audits and quality systems?
- Are incidents, complaints, and feedback analysed?
- Is there an improvement/action plan that is monitored?

Quality Statement 4: Staff Engagement & Wellbeing

- Do staff feel engaged and listened to?
- Are equality and diversity promoted?
- Is staff wellbeing supported (supervision, workload, absence)?

• Is progress against Ockenden action plans tracked and evidenced? **Quality Statement 4: Staff Engagement & Wellbeing** • Do staff feel listened to and supported in their roles? • Is staff wellbeing addressed (stress, burnout, flexible working)? • Is there an open culture to raise safety concerns? **Quality Statement 5: Information & Data Security** • Are maternity records (BadgerNet, electronic notes) accurate, accessible, and secure? • Is data used to improve outcomes (PReCePT, Saving Babies' Lives)? • Is information shared safely between maternity, neonatal, and community teams?	**Quality Statement 5: Information & Data Security** • Are records accurate and up to date? • Is data stored securely and shared appropriately? • Is information used to improve outcomes?

Appendix 3 Opportunity to engage with the KEMH maternity review

The King Edward VII Memorial Hospital (KEMH) are offering the opportunity for those with experience of using maternity services in the islands to engage with the maternity review.

The KEMH is undertaking a full external review of its maternity services in October this year.

As a starting point, the review will assess whether the action plan relating to the care of Baby Aspyn Hercules has been rigorously implemented. Baby Apsyn passed away in October 2023, and the subsequent reviews and Inquest into her death found failings in the care provided, with the Coroner determining that the death was avoidable.

The review will then look at the service more widely, assessing its current status, and identifying future service development and improvement opportunities.

The Terms of Reference for this review can be viewed at;
www.falklands.gov.fk/health/downloads

In order to objectively assess the performance of any service, it is essential that the views of service users are included.

The KEMH have been reviewing how it can collect service user information in relation to maternity services and have initiated a structured feedback form which is now given to all users once their treatment is completed.

However, in the past it is recognised that structured feedback was not collected, and that obtaining feedback from through forms is not the best way to engage with all service users.

The KEMH are therefore offering the opportunity for those with experience of using maternity services in the islands to engage with the review. This will be in two formats as below;

1. Direct feedback to the reviewers

We would like to hear from service users who have used the maternity service primarily over the past 5 years (although contact with the service further back in time will not be automatically discounted).

We have set-up an e-mail address that will be available between now and 3rd October, and which will only be available to be accessed by the reviewers; maternityreview@sec.gov.fk

The type of information you may wish to submit is personal to you, but we want to hear from as many services users as possible about their experiences, both good and bad.

Suggestions may include;

- Were you given enough information throughout your pregnancy?
- Did you feel that healthcare professionals asked about your preferences and acted upon them?
- If you were referred overseas, was the rationale for this clearly explained?

- Did you feel supported by the healthcare professionals treating you?
- Did you feel able to raise any concerns you had?
- Did you receive adequate support after birth?

This list is of suggestions only, and we would be glad to hear the feedback that you want to give, about the issues that are important to you.

The reviewers will acknowledge receipt of any information they receive, and may ask follow-up questions, or if mutually agreeable, to meet with you when they are in the islands between 7th to 13th October.

2. Maternity services champion

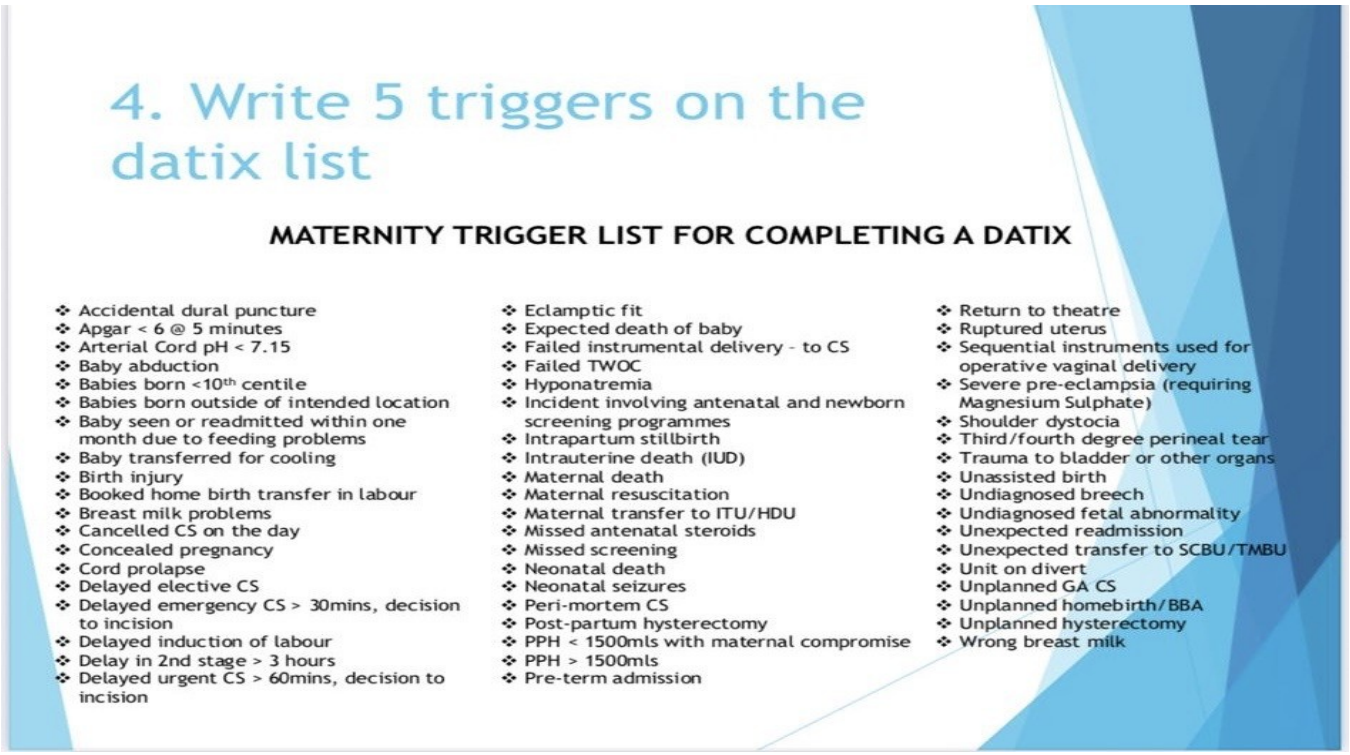
The reviewers are keen to engage with a representative from the local community to work collaboratively with them to help shape their enquiries, report and recommendations to be 'fit for the Falklands', and with service users at its heart.

This role is does not require experience in this area, or academic qualifications, rather a passion for improving maternity care and a willingness to meet with the reviewers on a couple of occasions is all that is required, in addition to having direct experience of using maternity services at the KEMH within the last 5 years.

The time commitment is not expected to be overly onerous, and the reviewers will try and arrange to meet at mutually convenient times.

If you are interested in an opportunity to help shape the future of maternity care in the Falkland Islands or require more information, please contact the reviewers at: maternityreview@sec.gov.fk

Appendix 4. Example of serious incident maternity trigger list



Appendix 5. Completed Assessment Tool

	Domain	Quality Statement	Audit Questions	Max Score	Score (1-4) 4 = Outstanding 3 = Good 2 = Requires Improvement 1 = Inadequat	Evidence / Notes	Score (1-4) 4 = Outstanding 3 = Good 2 = Requires Improvement 1 = Inadequat	Recommendations	Suggested Timeframe
1	Safe	Safeguarding	Are safeguarding policies up to date and embedded?	4	4	Policies are accessible on Q pulse.	4		
2	Safe	Safeguarding	Are staff trained in child/adult safeguarding including domestic abuse, modern slavery, FGM.	4	3	All maternity staff have level 3 safeguarding. For permanent staff mandatroy training is captured on q pulse and if our of date an alert is visible on that system however it wasn't clear what the process was for checking staff are in date, there didn't seem to be oversight or a system to ensure training does not lapse. Safeguarding training includes domestic abuse, modern slavery, FGM.Agency staff have STAM mandated as part of their contract.	3	Statutory and mandatory training should be reviewed at annual appraisals and should be a component on the rolling dashboard / tracker	6 months
3	Safe	Safeguarding	Are women asked if they feel safe? i.e screened for domestic violence	4	2	Inconsistent, question on EMIS printout in notes seen but not on every record. Evidence says women need to be asked multiple times before they disclose DV so good practice is to ask at every contact.	2	Ensure domestic violence questions are asked and documented regularly throughout pregnancy, i.e: do you feel safe in your relationship? Have you ever been fearful for yours or your childrens safety? Are you frightened of your partner or anothe person close to you? Does anyone exert control over you socially, sexually or financially?	Immediately
4	Safe	Safeguarding	Do women feel safe raising concerns about their care?	4	2	Small community, anonymity is an issue. In the feedback received confidentially to third party via email, there were a number of individuals who expressed difficulty in raising concerns and did not feel listened to or felt they would be treated differently if they made a complaint or that there was no point. Many said when they did complain they did not get replies. Conversely, in a recent postnatal survey conducted by KEMH of 8 most recently delivered women asked the question "did you feel listened to and involved in decision making" - all 8 responded with 'yes', however this feedback was via a staff member (independent from matermity)	2	Continue to gather feedback postnatally however consider if this would be more honest and useful by a third party such as maternity champion accepting that anonymous feedback is a challenge in the FI.	6 months
5	Safe	Risk Management	Are any new factors risks identified and acted on at all stages of maternity care?	4	2	At each contact the assessment box should be ticked, this is an assessment of change in risk factors from initial booking assessment.	2	Not routinely ticked in notes therefore unable to say with certainty that this is happening. Review and plan should be recorded in the handheld notes for new risks identified	Immediately
6	Safe	Risk Management	Are women involved in risk decisions (place of birth, VBAC, induction)?	4	2	Recent survey results:N=9 100% felt they were involved however this was not always clearly documented in the antenatal notes.	2	Plan as per 5, to continue feedback survey but also clearly document conversations and decisions made with women and families.	Immediately
7	Safe	Risk Management	Are high-risk pregnancies escalated appropriately?	4	2	MDT weekly where there is evidence of discussions now occuring and midwives feel able to raise concerns. Formal arrangement with UK Obstetric advisor to escalate to. New clinic arrangement on same day as scans allows for timely escalation for abnormal scan reports. SEAs and ultrasonographer highlighted difficulties in past with whom to escalate to.	2	Ensure all discussions are recorded in patient notes and shared with patient. Have a team approach and use obstetric adviser and connections in UK if any concerns about new symptoms or abnormal investigations or scan findings. Produce updated risk list to aid decision making especially in regard to transfers overseas and timing of a planned transfer when identified as high risk at the booking appointment.	Immediately
8	Safe	Staffing	Are staffing levels appropriate?	4	3	Yes however at times there are only 2 midwives on the island. At present midwives are dual trained and also work nursing shifts therefore it could be difficult to staff inpatient care lasting longer then 24 hours or longer inpatient stays. Plan for whole time midwife, starting this year. MO's cover obststetric, currently 3 available.	3	It was felt that a resident general obstetrician may not provide additional safety to care with lack of specialist feto-maternal knowledge in the FI and may provide a false sense of security full time; midwife due to start soon	12 months
9	Safe	Staffing	Is there an escalation plan in place for unsafe staffing?	4	4	Flexible rota to help cover attending maternity cases, staff are used to having to work ad hoc to cover at critical times as would be expected in remote care settings. Overtime or time in lieu is given.	4	untested situation, they just 'make do' if/when situation arises which is a fair response given setting	

10	Safe	Staffing	Are trained staff available to attend a neonatal and/or obstetric emergency?	4	4	Yes two maternity staff at delivery and team available on call also including auxillary staff who have been included in team.	4	Ensure everyone knows their role in an emergency via already practised skills drills	
11	Safe	Medicines	Are controlled drugs safely stored and administered?	4	4	Yes, kept in locked cupboard on ward as per legislation for safe storage of controlled drugs	4		
12	Safe	Medicines	Are errors/near misses recorded and acted on?	4	1	Q-pulse incident reporting/management system not currently utilised to its full potential in maternity. SI trigger list needed to prompt reporting, should include medicines errors/near misses to ensure these are collected, recorded and acted on.	1	Maternity line manager to take lead and work collaboratibely with governance to encourage reporting of all medication errors/near misses on Q pulse. Manager to review and outcome actions and disseminate learning of all cases at a regular obstetric governance meeting +/- M&M meeting	Immediately
13	Safe	Infection Prevention	Are IPC audits carried out in theatres, wards, and clinics?	4	3	No audit but theatres plate for CSSD. No HAIs identified in the past 5 years. Regular IPC meetings exist in KEMH	3	Consider regular audit schedule	>12 months
14	Safe	Infection Prevention	Are sepsis and GBS risks managed according to policy?	4	3	Sepsis protocol - can be found in Q Pulse general hospital section and posters; GBS protocol in maternity section; user feedback - late communication on GBS result but appropriately treated with antibiotics in labour	3	Recommend audit of GBS protocol and management; missed results should be included in the maternity trigger list for incident reporting	>12 months
15	Safe	Infection Prevention	Do staff follow hand hygiene and PPE protocols?	4	2	Hand hygiene-one audit produced- some compliance issues noted (only 80 ish %) but unclear plan in place to improve situation or re audit	2	re-eaudit practice following implementation of recommendations from previous audit	within 6 months
16	Safe	Learning from Incidents	Are serious incidents investigated openly?	4	3	Significant event analyses are completed on the three serious incidents of poor pregnancy outcome (stillbirth/ neonatal death) since 2023. The KEMH leadership team have invited external reviewers to investigate each of the SEAs. They also initiated this maternity review and demonstrated a culture of openness and willingness to learn from the reviews. It is unclear if other serious incidents (as per maternity trigger list or similar, see appendix) are captured or just not occured in FIs becaus of small numbers of annual maternity cases	3	develop SI trigger list, example in appendix of review document. - Q-pulse incident reporting/management system not currently utilised to its full potential in maternity. Maternity trigger list is needed to prompt reporting, should include any clincial incident, near miss, data breach, medicines errors/near misses as well as health and safety and staffing problems.	within 6 months
17	Safe	Learning from Incidents	Is learning from incidents shared with staff and families?	4	3	Families are offered a debrief appointment with the CMO to discuss the incident and findings. Following recent SEAs, learning was shared.	3	Continue to embed reporting of incidents on Q Pulse and learning from incidents into the monthly maternity governance meeting. Identify an additional list of triggers for incident reporting in maternity. Share incident and learning with maternity champion	Immediately
18	Safe	Learning from Incidents	Are changes made after incidents evidenced?	4	2	There was evidence of significant improvements after the last 3 serious incident reviewed so changes were made in response to SIs. Many of the changes were sustained and embedded in to practice, especially those where staff could see the value in the change. Some basic recommendations (to standardise care at antenatal appointments, ensure that all observations and checks were completed at each appointment, complete notes) were not.	2	Any implemented changes should be audited within a period such as 6 months to ensure full implementation and continued improvement is ensured	Immediately
19	Effective	Assessment & Planning	Are booking assessments comprehensive and updated?	4	2	Notes audit N=8 - yes on EMIS but not always documented in handheld records which are more comprehensive	2	Complete in handheld notes	immediately
20	Effective	Assessment & Planning	Are personalised care plans documented?	4	1	N=8 Not documented in section of handheld notes but documented on EMIS at an antenatal consultation hence not easy to find quickly in notes	1	Complete in handheld notes	immediately
21	Effective	Assessment &	Is continuity of carer delivered?	4	4	Yes	4	Fantastic continuity of care delivered in FI	
22	Effective	Nutrition & Feeding	Are women supported in infant feeding (BFI standards)?	4	2	Choice of feeding documented on maternity stat spreadsheet. Exclusive BF rates appear low and multiple service users complained that they were not supported, it was a theme from patient feedback data.	2	Midwives expressed challenges engaging community due to pre existing beliefs. Suggest Unicef Baby Friendly Iinitiative for training: dedicated AN BF class, discuss benefits AN at booking and again at 30-34/40, hand expressing from 36/40. Involve maternity champion, public health practitioners on benefits of BF.	>12 months
23	Effective	Staff Competence	Are staff trained in CTG, PROMPT, NLS, maternal resuscitation?	4	3	Maternity line manager is responsible for ensuring staff are in date however it was unclear as to how regularly or rigorously this was done.	3	Update Q Pulse to include the obstetric mandatory training in the mandatory list	immediately

24	Effective	Staff Competence	Are skills/drills completed and signed off?	4	4	Regular skills drills once per month	4	Keep record of training, attendance list with roles and dates	
25	Effective	Communication	Are interpreters, easy-read, and translated info available?	4	3	Numbers too low to evidence however resources are available. One user complained language was an issue. Language line is in use in FI	3	Use google translate and literature available from NHS Trusts as well as NHS online and Sussex LMNS which is available in oer 40 languages online.	> 12 months
26	Effective	Communication	Are handovers effective and safe?	4	1	No evidence of SBAR or similar handover in notes. No clear documentation of staff changover in notes or communication of situation/risks. All inpatient antenatal patients are handed over verbally at the KEMH staff morning huddle which is multidisciplinary in attendance - observed handovers and appear effective and safe but not written evidence of information imparted	1	Recommend use of SBAR stickers for care handover of all inpatients for evidence paricularly during labour	Immediately
27	Effective	Communication	Are women and families kept informed during emergencies?	4	2	Based on feedback gathered communication should be improved especially in regard to transfers.	2	Improve emergency transfer information (see in list of recommendation of main report)	6 months
28	Effective	Wellbeing & Choice	Are women supported to make informed choices?	4	3	N=8 felt they were supported however evidence from feedback suggested some people had less information then needed to make informed decisions.	3	Ensure PN survey is sent routinely, informed choice: use BRAIN acronym to aid decision making, document clearly	immediately
29	Effective	Wellbeing & Choice	Is perinatal mental health screening available?	4	1	Whooley questions page 'd' in antenatal notes but were not used in almost all notes reviewed	1	Again ensuring notes are completed covers this requirement	immediately
30	Effective	Wellbeing & Choice	Are mobility and pain relief options respected?	4	3	Now have epidurals, no water births available because fo risk of legionaire infection in KEMH. Some service users complained of room space however reviewers found space to be adeqaute. Issues with stock and supply of epidural bags at time of audit (no supply on island for a week or so)	3	Ensure birthing room is free of unnecessary equipment to give more space	immediately
31	Caring	Kindness & Dignity	Do women feel treated with kindness and respect?	4	3	Postnatal survey N=9 100% felt they were but email feedback less positive	3	Plan to continue feedback survey	immediately
32	Caring	Kindness & Dignity	Are privacy and dignity upheld in wards, clinics, and theatres?	4	3	Postnatal survey N=9 100% felt they were but email feedback less positive	3	Plan to continue feedback survey	immediately
33	Caring	Involving Women & Families	Do women feel listened to and involved in decisions?	4	3	Postnatal survey N=9 100% felt they were but email feedback less positive	3	Plan to continue feedback survey	immediately
34	Caring	Involving Women & Families	Are families included in neonatal care planning?	0	0	Not assessed	0	Introduce into feedback survey	immediately
35	Caring	Respect for Cultural Needs	Are cultural and religious needs respected?	4	3	N=8 100% felt they were but some feedback responses indicated cultural differences mattered	3	Plan to continue feedback survey	immediately
36	Caring	Respect for Cultural Needs	Are women's birth preferences documented and honoured?	4	2	Some evidence seen where this was documented on EMIS but recommend use of page 25 patients notes and ensure joint discussion	2	Encourage patients to read and fill out page 25 then discuss with midwife at next appointment	Immediately
37	Responsive	Personalisation & Diversity	Are maternity services tailored for diverse groups?	4	3	CoC ensures care is personalised but some of the feedback indicated younger mothers and immigrants feel less supported	3	Consider equity of vulnerable groups, discuss at MDT	immediately
38	Responsive	Personalisation & Diversity	Are outcomes by ethnicity and age monitored?	4	4	ethnicity and age monitored on maternity database	4		
39	Responsive	Personalisation & Diversity	Are adjustments in place for disability/communication?	4	4	Shower room has step but alternatives are available on the ward. Difficult to assess other parameters due to low numbers of deliveries.	4	Remember many resources available online through UK NHS websites	immediately
40	Responsive	Access to Care	Do women access booking by 10 weeks?	4	4	All women encourage to do so, stats being monitored and audited for compliance. Some unavoidable late bookers to be expected.	4	Continue to monitor.	
41	Responsive	Access to Care	Are delays in scans, inductions, and theatres monitored?	4	4	Evidence in SEA addressing issues with transport delay. Re scans, this happens very rarely and whilst it is possibility that IOL or ELCS would be delayed if someone else was in labour or if catastrophic event happened outside of maternity requiring anaesthetist or doctors would be unlikely to affect more than one other person and so this would be monitored.	4		
42	Responsive	Continuity & Transitions	Is antenatal-intrapartum-postnatal care seamless?	4	4	Yes as continuity model of care and small community. Only one GP surgery	4		

43	Responsive	Continuity & Transitions	Are neonatal transfers and discharges safe and coordinated?	4	4	Neonatal transfers would be off island and are coordinated inline with guidelines for all medical transfers.Neonatal incubater available.	4		
44	Responsive	Feedback & Complaints	Are MVPs and listening events active and impactful?	4	1	No MVP- steps made to involve community by naming maternity champion; Reviewers met with identified champion who is keen to embrace the role. Prior to this visit no formal feedback gathered of service user experiences, no listening events .	1	Formalise this role. Must be able to attend regular meetings 3-4 times annually and be invited to governance meetings. Must agree to governance and data protection guidelines of hospital. *Maternity Voices Partnerships (MVPs or MNVPs) are groups of service users (women, families, and their representatives) and maternity staff working together to improve maternity and neonatal services by providing feedback and co-producing solutions with maternity care providers and commissioners. Their main role is to ensure the voices and experiences of those using the services are heard and integrated into decision-making, ultimately aiming to improve the quality, safety, and experience of maternity and neonatal care for everyone* *Key role: build relationships that foster collaborative approach to improvement, gather feedback and share with providers, shape services by working with providers to co produce service development, ensure service user voices are heard especially those in disadvantaged groups.* *Aim to improve outcomes and ensure continuous improvement*	6 months
45	Responsive	Feedback & Complaints	Are complaints investigated and learning shared?	4	2	Feedback indicated that at least complaint not resolved or that people feel they are not able to complain anonymously and without repurcussions.	2	Complaints are investigated and learning shared but process may need to be made more robust and to full resolution with feedback to complainant	6 months
46	Well-Led	Leadership & Culture	Do staff describe leadership as visible and supportive?	4	3	Interviews with midwives: feel that leadership is visible and supportive - provided examples eg when mw sought to discuss a case in which she felt not listened to by the MO - felt listened to by CMO and action taken; both midwives feel very supported by senior midwife who is always available and always supportive and staff anonymous survey indicated that senior leadership visible at morning huddle. Staff survey 54% said yes.	3	Ensure an escalation policy for maternity staff	> 12 months
47	Well-Led	Leadership & Culture	Is there a culture of openness and learning?	4	3	Following the external review presentation and report in March 2024 the leadership team and staff demonstrated a strong willingness to learn and change practice. There is as a result throughout KEMH a culture which is very different to our previous visit of openness and a willingness to prioritise and ensure safety in maternity cases and to learn from events. Incidents are discussed at the weekly obstetric MDT and at the 3 monthly M&M meeting; Staff survey 64% said yes	3	Ensure learning is shared with wider team and the maternity champion to further develop the culture of openness to the community	> 12 months
48	Well-Led	Vision, Strategy & Values	Is there a clear maternity improvement plan?	4	3	The recommendations made from the external obstetric review forms the basis of maternity improvement plan which includes recommendations from Ockenden/Kirkup and other recent national reports - significant progress has been made to implement recommendations - see action tracker	3	maternity improvement plan in place (action tracker)	6 months
49	Well-Led	Vision, Strategy & Values	Are staff and families engaged in shaping priorities?	4	3	Both staff and families on being consulted have shown enthusiasm and dedication to engage in advising on future strategy (staff interview/survey and service user email feedback and maternity champion. Examples of good practice include development by one of the midwives of a summary sheet for the maternity notes; introduction of antenatal classes which have been well received; handheld notes contained in a wallet with general information for the user on front which includes how to access urgent care and trigger list for accessing care out of hours as well as signposts to helpful websites for pregnancy information	3	Invite maternity champion to a regular (eg 3 monthly) maternity governance meeting with members of the MDT to review recent pregnancy outcomes, hear feedback from users through champion, assess dashboard and update on planned changes	6 months

50	Well-Led	Governance & Improvement	Is maternity governance strong (dashboards, standards)?	4	2	Improvement is seen in maternity governance since last visit: Weekly update of live excel database of current pregnancies made in preparation of Thursday MDT with section of recently delivered, who is currently overseas for delivery, staff present at each meeting and topics covered at the meetings including education component. Action tracker in place of dashboard. Some of the standards have been assessed by audit of practice. It is planned that obstetric advisor will review service annually by way of standard setting; Good progress with development of maternity guidelines and education of staff; Evidence of some completed audits; Progress made with better medical record keeping;	2	Modify action tracker which was set up following obstetric review going forward to provide the framework/dashboard for working towards standards/ implementation of current and future national reports. Engage with the KEMH incident reporting tool. Create maternity trigger list for incidents that should be reported. Discuss at monthly maternity governance MDT with maternity champion present. Create database of mandatory audits to assess standards with recorded recommendations from findings and date/timings of re-audits to embed these into routine practice/regular review. Consider medical notes audit every 3 months to embed use of handheld notes. Patient safety - audit completion of safeguarding questions and risk assessments	>12 months
51	Well-Led	Governance & Improvement	Are risks reviewed at Board level?	4	4	Risk register discussed at HMSC	4		
52	Well-Led	Governance & Improvement	Is progress against action plans monitored?	4	4	yes - see action tracker	4		
53	Well-Led	Staff Engagement & Wellbeing	Do staff feel listened to and supported?	4	2	Saff survey 58% said yes	2	Encourage line managers to regularly engage with the staff they support to improve on 58%	> 12 months
54	Well-Led	Staff Engagement & Wellbeing	Is wellbeing (stress, burnout) addressed?	4	2	Staff survey 44% said yes	2	Immediate de-brief with ongoing follow up for staff involved in distressing situations	> 12 months
55	Well-Led	Staff Engagement & Wellbeing	Is there a safe culture for raising concerns?	4	3	Staff survey 72% said yes	3	all staff should feel they can raise concerns	> 12 months
56	Well-Led	Information & Data Security	Are maternity records accurate, secure, and accessible?	4	1	Hand held patients records audited N=8 against audit proforma. Many had missing information (observations, names) or information in multiple locations (digital and written but not neccessarily all/same iformation in both places meaning no one record was contemporaneously written) so were not accurate accounts of a care episode. Some documentation (CTGs) were not secured safely. Notes stored in hospital securely inline with data protection guidelines.	1	encourage completion of women's hand held notes with eg summary line on Emis rather than printout of Emis placed in hand held notes. Ensure that viewpoint US reports are placed in the hand held notes (securely) and complete by hand the blood results on the required page in the notes	Immediately
57	Well-Led	Information & Data Security	Is data used to improve outcomes (MBRRACE, Saving Babies' Lives)?	4	2	Excel database of pregnancy outcomes - now completed live weekly at MDT and will help improve outcomes once data collated, audited and quality improvements initiatives undertaken and embedded.	2	Continue to record pregnancy details and outcomes to maintain up to date rolling database of pregnancy outcomes which can help inform clinical priorities for change.	>12 months

Summary & Scoring

Domain	Max Score	Your Score	%	Rating
Safe	72	49	0.681	Good
Effective	48	29	0.604	Requires Improvement
Caring	20	14	0.7	Good
Responsive	36	30	0.833	Good
Well-Led	48	32	0.667	Good
Overall	**224**	**154**	**0.688**	**Good**

Appendix 6: Action plan progress

Action Plan following Significant Adverse Event Review – Baby Aspyn Hercules

Progress/Indicator RAG Status	
	Work is significantly behind schedule and no progress has been made and/or progress has been made but the timescale has not been achieved
	Progress is being made, progress is good and the action is likely to be achieved within timescale. Or the action has been completed but evidence is required to demonstrate achievement.
	The action has been completed and there is a record of evidence to support its completion
	The Action is ongoing – and will be continually monitored

Recommendation Number	Specific Action (s)	Target Date	Expected Outcome	Lead	RAG Rating	Completion Date/ Update	Reviewers Critique and progress assessment
As written in both the external and Internal and reports *(Numbers in brackets relate to recommendations as documented in external review report*	*Indicate the actions or series of actions to be taken to achieve expected outcome. They must be SMART.* *Examples might be delivering training, developing new policy, introducing new standard, reviewing working practices etc.*	*Indicate the realistic time-frame*	*Describe what improvements/changes to practice etc. that should result from Actions*	*Identify the lead person who will be accountable for completing the action.*		*On completion, list supporting evidence*	*Comments*
POLICIES AND PROCEDURES							
1.Review and up-date current KEMH antenatal guideline and care pathway (2) Agreed to use guidelines from Truro (28/08/2025)	Planned review dates have been agreed	August 2024	Current guidelines routinely reviewed and up-dated **31/10/2024** Regular reviews undertaken	CMO/CNO		**October 2024** All guidelines have been reviewed. When a new substantive	Guidelines accessible on y drive for maternity staff and available on q pulse. Antenatal guideline reviewed – KEMH adopted guideline in use.

						Consultant Obstetrician is appointed further review will additionally occur.	**RECOMMENDATION:** To draft fetal monitoring guideline, and with recent introduction of Dawes Redman antenatal CTG to KEMH - to include this in this guideline **RECOMMENDATION:** complete fetal monitoring guideline, refer to Royal Cornwall or UHSussex guidance until adapted and published for KEMH.
2.Follow NICE diabetes in pregnancy guidance for detection and management of gestational and pre-existing diabetes (7 +)	Ensure links are available on computer devices accessed by clinicians	May 2024	Staff use NICE guidance to detect and treat gestational diabetes **Completed**	DSA	**As per DHSS Recommendations** **23/09/2025**	**May 2024** (HbA1C taken at booking. Hyperlinks to guidelines to be included in all documents)	Additional guidance SBL v3.2 element 6- care of pre-existing diabetes to adopt as far as possible/adapt for KEMH; T1DM referred to UK from booking, consider early transfer of T2DM if glycaemic control suboptimal at booking or 28 wks; all pregnancies with diabetes to be transferred off FI for delivery Draft guideline reviewed and consistent with NICE **RECOMMENDATION:** modify as above and publish.
Recommendation Number	**Specific Action (s)**	**Target Date**	**Expected Outcome**	**Lead**	**RAG Rating**	**Completion Date/Update**	
3. Ensure RCOG venous thromboembolism (VTE) guidance is followed. (8) Re-assess for VTE Postnatally	VTE undertaken at booking but not post-natal at present		Audit of clinical records **Completed**	All staff dealing with obstetrics		**31/10/2024**	Guideline under review and available on y drive for maternity staff at present.

			(CNO has undertaken an Audit of Midwifery cases – from Electronic Patient Record System = EMIS) Perinatal Institution -Perinatal Record Booklets in use where guidance is followed and documented - resulting in auditable evidence			Booklets arrived and in use **06/05/2025 VTE assessment documented in both EMIS and handheld booklets**	AN EMIS audit of N=10 records showed that 9/10 had and antenatal VTE assessment clearly logged. PN VTE assessment not documented routinely. **RECOMMENDATIONS:** publish guideline. Improve documentation of VTE assessments. If printouts used for EMIS, complete also in handheld notes for clarity
4. Create a local Intrapartum guideline with up-dated analgesia in labour options (16)	Possibility of providing epidurals	August 2024	Current guidelines routinely reviewed and up-dated Guidance for epidurals completed and in use.	Anaesthetist	**29/09/2025** **Changed to Blue *PRE-GL-2**	**Nov 2024** Guidance for epidurals completed and in use.	Guidelines in date and appropriate
5. Up-date IOL guidelines (17)	Review and revise guidelines and placed on Q-Pulse **06/05/2025 Training on the insertion of Cook Balloon to be delivered by CMO**	Jan 2025	Current guidelines routinely reviewed and up-dated GEN-PRO-7 on Q-Pulse – requires review to include Cook balloons and Propess	CMO/CNO CMO to action prior to next review in Sept.	**Amber to green** **28/08/2025** ***Now changed to PRE-PRO-1**	**Jan 2025 Revised Policy up-loaded onto Q-Pulse *GEN-PRO-7 06/05/2025**	Guideline includes section on Cookes balloon insertion
DOCUMENTATION							
6. Re-introduce Perinatal Institute (PI) handheld antenatal notes (1) Introduce Perinatal Institute postnatal medical notes booklet	CNO to source and order appropriate notes /stickers following on-line training which is being undertaken in June 2024	September 2024	Use of consistent and standardised notes for all pregnancies (See 3.) 05/06/2025	CNO	**As per DHSS Recommendations**	**31/10/2024** All documentation specified in column 1 now	These have been introduced but are not being used exclusively and therefore not effectively. A notes review of N=10 sets demonstrated a lack of

Re-Introduce intrapartum pregnancy notes with partogram and delivery page (24) CTG and VE interpretation stickers – clear contemporaneous documentation (25)	31/10/2024 – Individualised Growth Chart – CMO to Liaise with Radiographer		CTG Stickers to be obtained/developed within the next month VE stickers in use		**23/09/2025** **Changed from Amber to Green 19/09/2025**	in routine use, expect as noted below; **19/09/2025 CTG Stickers unavailable. CTG Interpretation Documents have now been introduced**	consistency and adherence to basic observations such as BP and urinalysis. Some We saw no evidence of CTG stickers, VE stickers were seen but not used in every set. No evidence of SBAR handovers. There were examples where entries were not documented contemporaneously and many entries were not timed/dated/signed with name and designation as per NMC code. **RECOMMENDATIONS:** Use notes booklets fully, move away from reliance on EMIS printouts. Use stickers consistently. Use SBAR for handovers. Use CTG review sheet for labour as CTG sticker (would fit on 4 per page sticker sheet)
Recommendation Number	**Specific Action (s)**	**Target Date**	**Expected Outcome**	**Lead**	**RAG Rating**	**Completion Date/Update**	
7. Introduce modified early obstetric warning system (MEOWS) chart for all pregnant in-patients (18)	CNO to make modifications – new chart to be placed on Q-Pulse	May 2024	Notes contain modified MEOWS charts	CNO	**29/09/2025** **Changed to Blue *PRE-CHA-1**	**May 2024** (in use)	Evidence this is embedded in practice and filed on Q pulse as guideline. new National MEWS chart (2025) https://www.e-lfh.org.uk/programmes/maternal-and-neonatal-deterioration/ In use

8. Poster on theatre wall re CS categories and timeframes for attendance (28)	Theatre manager to ensure that it complies with revised guidance **06/05/2025 Theatre, Ward office, Maternity all display these instructions**	May 2024	All theatre staff aware of location and instructions	CMO/Theatre Manager	**29/09/2025** **Changed to Blue *PRE-GL-4**	**May 2024** (Classification document produced and displayed on theatre and ward) ***PRE-GL-4**	Posters seen displayed in theatre and outside delivery room
9. Adapt WHO checklist (30)	To include 'Label Specimens' and 'Cord Blood' and placed on Q-Pulse	May 2024	Checklist modified and in use	Theatre Manager	**29/09/2025** **Changed to Blue *THT-FOR-5**	**May 2024** (Completed and placed on Q-Pulse) ***THT-FOR-5**	Evidenced in maternity notes of women delivered by CS
TRAINING & DEVELOPMENT							
1. Midwives should have the opportunity to refresh their practice. (4) Numbers 15 and 18 to be merged under this heading (15. PROMPT training (35)) (18 Additional annual Obstetric training for doctors/midwives (39))	Opportunity to work in busy unit – however this will require significant funding	January 2025	Placement for substantive midwife arranged to occur December 2024. Training to include; Newborn life support, PROMPT, foetal wellbeing and maternity update. Will also include time on maternity ward at JRH.	DHSS Ongoing	**As per DHSS Recommendations** **23/09/2025**	**31/10/2024** Changed to Amber as Midwives and those GP's dealing with obstetrics have undergone training, but some items still to be completed before year end 2024 as detailed. **06/05/2025 CNO has completed overseas training and refresher and has agreed in-**	**RECOMMENDATION:** Ensure that all recommended obstetric specific training is tracked by appropriate line manager with timely retraining and can be evidenced in Q Pulse. Consider reviewing this annually as part of appraisal.

						year training programme.	
2. Simulation to identify barriers to delivery within the timeframe (29) Simulation of umbilical simulation identified 28/08/2025	Develop training scenarios and put into routine practice – include ward staff so they are familiar with their roles and responsibilities in the event of an emergency	Novembe r 2024	Regular simulations practised by staff – including ward staff These include: Shoulder Dystocia, Post-Partum Haemorrhage, Newborn Resuscitation and Eclampsia Breech Birth (Training documented on Q-Pulse)	CMO/CNO Include all relevant staff	**Revert ed back to amber** **28/08/ 2025** **Ongoin g** **19/09/ 2025** **Agreed to revert back to Green**	**31/10/2024** Simulations are being practised with each consultant Obstetrician that visits. **06/05/2025 Introduction of regular 2 monthly training sessions- CMO to lead**	Evidence of recent regular sim training
Recommendation Number	**Specific Action (s)**	**Target Date**	**Expected Outcome**	**Lead**	**RAG Rating**	**Completion Date/Update**	
3. Education re paired cord blood sampling (31)	Provide training for arterial and venous cord blood sampling	August 2024	Relevant staff are proficient in blood sampling Introduction of Guidelines - May 2024 (GEN-GL-31 – Cord Blood Sampling) on Q-Pulse		***PRE-GL-3**	**May 2024** (guideline produced) ***GEN-GL-31 changed to PRE-GL-3 (Sept 25)**	Guideline seen and appropriate
4. Mandatory annual CTG training for all staff involved in delivering obstetric care (34)	E-learning courses available	August 2024	Evidence of completed training Completed training documented on Q-Pulse	All staff dealing with obstetrics	**As per DHSS Recom menda tions** **23/09/ 2025** ***all trainin**	**06/05/2025 Baby Life line, K2 & eLFHprovide such courses. All current obstetric staff have completed, and now part**	**RECOMMENDATION:** Ensure annual updates. Ensure this is required of agency staff also.

					g to be logged on Q-Pulse	**of rolling mandatory training.**	
5. PROMPT training (35) as above -28/08/2025							**RECOMMENDATION:** Ensure annual updates. Ensure this is required of agency staff also.
6. Teamwork/Communication/ Human Factors education (36) Encourage a culture of reporting adverse incidents and subsequent learning (42)	Provide regular training. HGM to devise and present HF training with emphasis on communication	April 2025	Training delivered – evidence of attendance	HGM	**As per DHSS Recommendations 23/09/2025 *all training to be logged on Q-Pulse**	**31/10/2024** Training has been delivered. Regular training sessions to continue **06/05/2025 Continue in-house training and consider adding newly identified eLFH to mandatory training.**	Evidence of recent training **RECOMMENDATION:** ensure that all training sessions, topics and attendees are detailed in either the obstetric y drive datasheet or Q pulse
6b. Encourage a culture of reporting adverse incidents and subsequent learning (42)							Evidence of discussion at MDT of incidents and learning **RECOMMENDATION:** use Q pulse for all incident reporting. Agree obstetric trigger list for incident reporting (example list appended)
7. Learning from Incidents – regular incident review meetings (38)	Anaesthetist led M & M meetings	April 2024	Quarterly M & M meetings held – record of discussion to be documented	Anaesthetist		**31/10/2024** Occurs and is on-going	**RECOMMENDATION:** In addition to M&M meeting incidents should be discussed monthly in obstetric MDT and learning shared with wider team

							and with maternity champion
8. Additional annual Obstetric training for doctors/midwives (39)	Please refer to 11,12,13,14,15						**RECOMMENDATION:** Improve governance and log training to ensure and consider linking annual/rolling training review in annual appraisals. *Applies to 4,5,6 also*
CLINICAL PRACTICE							
9. Introduce a GP/Medical officer antenatal clinic. (5)	Doctor's Rota to include antenatal clinics	April 2024	Doctors to routinely undertake antenatal clinics	CMO	**29/09/2025** **Changed to Blue**	**April 2024** In place	Weds afternoon MDT clinics after scans in place and working well as cases are discussed by MDT following day in ringfenced maternity meeting.
Recommendation Number	**Specific Action (s)**	**Target Date**	**Expected Outcome**	**Lead**	**RAG Rating**	**Completion Date/Update**	
10. Antenatal care to be provided by a team of midwives working together, with each accepting additional responsibilities for service/practice development, quality improvement (3) Re-introduce antenatal education/classes and infant feeding (10) Signpost the pregnant person to useful on-line patient information leaflets (11)	Employ an additional F/T midwife Midwives provide this service Midwives with the assistance from DSA – identify links/leaflets and ensure they are readily available	November 2024	Introduction of midwife led clinics including HV Pregnant women are provided with current information	CMO/CNO	**19/09/2025 Changed from Amber to Green**	**31/10/2024** Changed to Amber as agency provide midwives, but recruitment efforts continue **06/05/2025 Offer has been accepted** **May 2024** Classes due to commence 27th May.	Evidence of team involvement in the development and reinstatement of antenatal classes. Women provided with notes wallet that includes contact numbers, when to call, websites, healthy eating. Information in perinatal notes not being used. **RECOMMENDATION:** perinatal notes include lots of information, encourage women to read and be

						31/10/24 Classes are in place and signposting occurs	involved in their notes i.e. filling in birth plans.
11. Birth plan and postpartum contraception should be discussed at 34 weeks and finalised at 36 weeks (12)	Per column 1	May 2024	Discussion documented	All staff dealing with obstetrics	**As per DHSS Recommendations** **23/09/2025**	**May 2024** In place	Audit of notes: birth plans **a**re not being completed in handheld notes. Evidence of birthplan discussion on EMIS and postnatal contraception is consistently addressed. **RECOMMENDATION:** Change to green status once evidence of implementation seen in re-audit of birthplan completion in hand held notes
12. Any pregnant person identified as requiring CS and IOL to be seen by GP/Medical Officer and procedures booked by them. (13) Consider if antenatal anaesthetic review is required for all planned CSs and potentially those admitted for IOL (14)	Clear lines of communication for referral	May 2024	Doctors review all pregnant persons requiring CS and IOL Seen by anaesthetist at 32 weeks (to be included in Dedicare Contract) **Change 32 weeks to 3rd Trimester 28/08/2025**	All staff dealing with obstetrics	**As per DHSS Recommendations** **23/09/2025**	**May 2024** In place	Evidence of implementation (audit of maternity notes)
13. Medical officer review on admission for induction (19)	Clear lines of communication for referral	May 2024	Doctors review all pregnant persons requiring CS and IOL	All staff dealing with obstetrics		**May 2024** In place	Evidence of implementation (notes review)
14. Theatre team, surgeon, anaesthetist to be in close proximity (within 15 minutes) when on-going maternity case (22)	Ensure this is clearly documented in Dedicare contracts	April 2024	Confirmed with Dedicare that contracts have been revised	CM0	**29/09/2025** **Changed to Blue**	**April 2024** Actioned and in place	Evidence of implementation (notes review)

					***GEN-POL-7**	*On-call Policy denotes response times	
15. Medical review if not ARM'able after second prostin (20)	Contact Doctor after second prostin	May 2024	Clear documentation of review by Doctor	All staff dealing with obstetrics			Doctors now called to review but not in guideline **RECOMMENDATION:** Update IOL guidelien to recommend medical review at start of induction
Recommendation Number	**Specific Action (s)**	**Target Date**	**Expected Outcome**	**Lead**	**RAG Rating**	**Completion Date/Update**	
16. Evidence of Handovers – use of SBAR (44)	Develop and introduce SBAR forms	April 2024	Introduce SBAR forms for ward **Addition to be made to current form to include 'D'=Documentation 28/08/2025**	HGM		**April 2024** (Form produced – on Q-Pulse and distributed to Ward and A&E) **05/06/2025 Add 'D' to SBAR D= Documentation of Handovers**	No SBARs seen in notes audit N=10 **RECOMMENDATION:** Introduce SBAR sticker to add to notes in place of form to maintain continuity of timeline in maternity notes and to clearly identify when hand over occurs
17. Formalise external out of hours obstetric advice/antenatal expert advice (46)	Identify specific experts who are able to provide this service	October 2024	Staff have access to expert advice out-side normal hours	CMO		**May 2024** (Long term expertise to be arranged – but at present provided by Sophia Stone until links with Cornwall formalised. **06/05/2025 Link with Royal Cornwall**	Link with Royal Cornwall Consultant Obstetrician and Fetal Medicine formalised for expert obstetric advice

						Hospitals now formalised	
18. Prescribe/Administer progesterone only contraception immediately after deliver	Discuss with pregnant person	May 2024	Pregnant person involved in clinical decision making	All staff dealing with obstetrics	**As per DHSS Recommendations** **23/09/2025**	**May 2024** Practice has been updated to include this discussion.	Evidence of discussions in notes review
19. Consider routine 32 and 36 week growth scans (9)	As per column 1	May 2024	Included in relevant guidance	CMO/Radiographer	**29/09/2025** **Changed to Blue *PRE-PRO-5**	**May 2024** Guidance completed *IMA-PRO-1 changed to PRE-PRO-5	Implemented with additional scan at 24 weeks for high risk and routine 28 week scan for all. **RECOMMENDATION:** all obstetric staff receive regular update/training on interpretation of scan reports and subsequent management plans (in keeping with SBL v3)
20. CS categorisation with clear communication to the theatre team (26)	Clearly defined categorisations are documented and staff responsibilities for each		All staff aware of the classification of CS categorisation	CMO	**29/09/2025** **Changed to Blue *PRE-GL-4**	**April 2024** Guidance introduced	Guideline available and poster outside theatre and delivery room
21. Record and Review all pregnancies and their outcomes – including those delivering overseas (45)	To be discussed at M&M meetings **06/05/2025** **All complex cases to be presented at M&M meetings, including those requiring epidurals and those who have been sent away.**	November 2024	Documented evidence of all pregnancies with outcomes completed annually **06/05/2025** **Regular reviews undertaken and documented on shared spread sheet.** **Audit of wound infections has been completed**	CMO/CNO / Sonographer/Theatre Team/Anaesthetist	**As per DHSS Recommendations** **23/09/2025**	**06/05/2025 RAG Rating changed to green**	Spreadsheet has been created, and all current pregnancies are logged and discussed weekly at MDT. Outcomes are documented. Issues raised are that discharge summaries are not always forthcoming from overseas deliveries.

	2 weekly reviews of all pregnancies introduced						
Recommendation Number	**Specific Action (s)**	**Target Date**	**Expected Outcome**	**Lead**	**RAG Rating**	**Completion Date/Update**	
22. Cat 1 CS – emergency bell/whole team approach – transfer pt immediately to theatre (27)	Regular simulations (See number 12)	May 2024	All staff to react and respond to emergencies	CMO/CNO	**As per DHSS Recommendations 23/09/2025**	**31/10/2024 completed**	Auxiliaries also involved in training to assist transfers. Simulations and skills drills commenced. **RECOMMENDATION:** formalise schedule and log as evidence with attendance list to ensure all staff have attended and been involved.
LEADERSHIP							
23. Clarify roles (32) Local Doctor to drive process (33)	Roles and responsibilities of staff clearly defined (See numbers 24 & 27)	May 2024	Staff aware of specific roles and escalation process	CMO		**May 2024** (All staff, including agency, have roles identified)	
GOVERNANCE/AUDIT							
24. Introduce/update a number of guidelines with regular audit of practice (41)	Identify clinical audit targets **06/05/2025 Audit on wound infections following C Section undertaken – results documented. Review of Hand- Held records undertaken at each 2 weekly meeting**	November 2024	Regular audits undertaken including record keeping	CNO/CMO		**06/05/2025 Audits performed** **RAG Rating changed to green**	Many guidelines remain in draft and require completion hence work in progress and changed rag rating to 'orange'. **RECOMMENDATION:** Continue to complete guidelines, disseminate and audit and re-audit clinical practice. Ensure guidelines all filed in same place in an accessible folder
25. Involve service user/stakeholder involvement in obstetric service planning (47)	Use of surveys/questionnaires	November 2024	Service meets patient expectations	Midwives/ HV	**Changed from red to**	Intention to introduce patient	Feedback received as part of external review. Themes and direct quotes

	06/05/2025 **CNO Presented a questionnaire.** **Meeting with DHSS arranged in order to review and adapt to our specific needs** **It is anticipated that the questionnaire will be given to service users at booking – completed questionnaires will be returned to HV at initial visit post delivery**		CMO to write to individual concerned – offering Stakeholder involvement in service delivery [actioned] **06/05/2025 – Questionnaire will provide evidence of service user experience**		**amber – surveys in use 28/08/2025**	satisfaction survey from January 2025. Planned service user engagement in future external review of maternity services that will occur late 2025/ early 2026. **19/09/2025** **No meaningful data at present - therefore current practice not influenced**	produced and will be shared in report. Several expressions of interest for maternity champion- one identified and offered chance to meet with external reviewers. Feedback of recent deliveries also gathered by KEMH staff member. Plan to continue this. **RECOMMENDATION:** formalise role of maternity champion (look to maternity voices partnership model in UK) (include governance lead in discussion & avoiding exposure to confidential patient details). If continuing to gather feedback postnatally, ensure women and families can share information safely and as anonymously as possible, offer debrief with maternity staff if signs of distress.
INTERNAL ACTION PLAN (numbers in brackets relate to recommendation number)	**Specific Action (s)**	**Target Date**	**Expected Outcome**	**Lead**	**RAG Rating**	**Completion Date**	
1. Clearly define the roles of the visiting specialists (See 24)	Contracts for visiting specialist clearly define their roles and highlight the need to discuss & establish clinical leadership in the event of an emergency.	**01/01/2024**	Roles are responsibilities are clearly defined	CMO/Practice Manager		**01/01/24** Completed – Contracts for visiting specialists clearly state and define roles	Evidenced

2. Clearly define the categories of c-sections and this is to include when the patient will be moved to the operating department. (See 30/32) Encourage clear lines of communication between all teams and emergency call-in processes (See 30/32)	Guideline written related to categories of c-section and time it is expected to take to deliver the baby. All Cat 1 & 2 sections will be moved directly to the operating theatre. Evidence that all staff have been reminded that it is essential to clearly communicate between teams during emergencies. Refresh the emergency call-in process.	**01/01/2024**	Guideline produced Human factors training delivered- see 16 Call-in process reviewed and changes implemented	CMO/CNO All senior Clinicians	**29/09/2025** **Changed to Blue *PRE-GL4**	**April 2024** Guidelines drawn up and placed on Q-Pulse (GEN-GL-32). Page 3 of the document clearly evident in theatre and ward for ease of reference Training delivered. On-call policy for DHSS staff reviewed and amended. Contracts for anaesthetist/ Dedicare staff reviewed and amended. Emergency C-Sections have occurred post review – with clear lines of communication between staff	**RECOMMENDATION:** Ensure new staff are orientated/inducted to this also.
3. Encourage constructive, questioning, professional challenge between all members of the KEMH team (see 16)	Evidence of discussion of the importance of constructive professional challenge being encouraged across the KEMH.	**01/03/2024**	Staff have attended Human Factors Training	All members of SMT	**As per DHSS Recommendations** **23/09/2025**	**31/10/2024** Attendance documented on Q-Pulse	**RECOMMENDATION:** annual training for all staff

4. Relevant maternity cases are to be formally discussed at the morning team ward round. (See 26/33) Review the surgeon and anaesthetist on-call policy. (See 24)	Evidence this practice is embedded within the structure of the ward round discussion. On-call policy re-written and reviews and agreed with all parties.	**01/01/2024** **01/04/2024**	All maternity cases routinely discussed at ward round Policy reviewed and revised	CMO/CNO	**As per DHSS Recommendations** **23/09/2025**	**May 2024** Implemented into routine practice **May 2024** Policy reviewed and placed on Q-Pulse (GEN-POL-7).	Evidenced this week on site
INTERNAL ACTION PLAN (numbers in brackets relate to recommendation number)	**Specific Action (s)**	**Target Date**	**Expected Outcome**	**Lead**	**RAG Rating**	**Completion Date**	
5. Secure additional training for obstetric staff. (See 18) Continue regular aeromed training programme. Support current schedule	Include in the 24/25 budget additional finances to support regular obstetric upskilling for obs Dr's and midwives. Evidence of regular aeromed training.	**31/07/2024**	Training identified and undertaken as reasonably practicable and documented on Q-Pulse Regular training occurs in conjunction with MPC staff.	DHSS/CMO/ CNO	**29/09/2025** **Changed to Blue**	**31/10/2024** Changed to Green Documented training on Q-Pulse On-going- as arranged by MPC personnel	**RECOMMENDATION:** Evidence of training
6. Review the current nurse call bell system	Review of the suitability, or possible improvement, of the current nurse-all system.	**31/07/2024**	Improve current system or new system installed	CNO, HM and Hosp. Engineer	**29/09/2025** **Changed to Blue**	**31/10/2024 Completed** Changed to Green, new system installed and functioning.	**RECOMMENDATION:** Ensure checked daily or prior to admissions.
7. External review of events	Funding will have to be agreed to support a Consultant obstetrician and senior midwife to come and review this case and our customs, practices and policies. This should be a site visit and ideally should be held within 6 months,	**31/07/2024**	External review of SEA occurs	DHSS/CMO/ HM		See attached report; completed by Sophia Stone and Heather Woods	Since last external report further two SEAs conducted and assessed as high quality and appropriate conclusions drawn.

	although it is recognised this may take longer.						

26/04/2024 – meeting held to discuss and review V.1. which was initially drawn up by CMO and HGM. In attendance: CMO – Dr R Edwards, CNO – Mandy Heathman, HGM – Janette Vincent, Midwife – Beauller Manomamano , Dr S.Browne, Dr M. Weinig, Theatre Manage – Eric Black, ODP – David Ashbridge, Decontamination Supervisor – Clare Crowie
Changes made to RAG rating as these have been actioned and/or implemented.
It was agreed that the On-Call policy to be reviewed to reflect the attendance of theatre team in the event of an obstetric emergency.

17/05/2024 – meeting held to review V.2. In attendance DHSS, CMO, CNO HGM. Draft V.3 completed following this meeting – with changes to RAG rating and inclusion of evidence of action taken.

31/10/2024 – meeting held to review V.3. In attendance DHSS, CMO, CNO, HGM. Draft V.4 completed following this meeting – with changes to RAG rating and inclusion of evidence of action taken.

On-call Policy has been reviewed – V4.2 (GEN-POL-7) and has been placed on Q-Pulse

06/05/2025 – meeting held to review V.4. In attendance DHSS, CMO, CNO & HGM. Draft V.5 completed following this meeting.

12/05/2025 – Draft V5.1 drawn up – incorporating changes identified in V.5

28/08/2025 – meeting held to discuss Action Plan and Midwifery Cases. In attendance Dr M Weinig, Mandy Heathman (CNO), Dr F Chirnside, Dr J Tewson, Nina Aldridge (Radiographer) Caitlyn Durkan (Locum Midwife) J Vincent (HGM). Draft V5.2 drawn up following this meeting.

19/09/2025 – meeting held to discuss Draft Action Plan V5.2. In attendance DHSS, CMO, CNO & HGM. It was agreed to incorporate a 'blue' RAG Indicator – noting that the action was complete but will be continually monitored. With regard to All Policies, Procedures, Guidelines etc. relating to 'Pregnancy' – these are to be categorised on Q-Pulse (Document Module) with the prefix '**PRE- '**for ease of locating, accessing and reviewing. Draft V6 drawn up and distributed.

29/09/2025 – As recommended by DHSS on 23/09/2025 – Review undertaken with regard 'blue' RAG' status – Draft V.6.1 drawn up and shared with DHSS,CMO,CNO

07/10/2025 – Following discussion with DHSS on 04/10/2025 – modifications made with regard to 'Blue' RAG status. Draft V.7 now complet